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PHYSICIAN AND PATIENT

LONDON : HUMPHREY MILFORD
OXFORD UNIVERSITY PRESS

PHYSICIAN AND PATIENT

PERSONAL CARE

Edited by

L. Eugene Emerson

CAMBRIDGE
HARVARD UNIVERSITY PRESS
1929

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PRINTED AT THE HARVARD UNIVERSITY PRESS
CAMBRIDGE, MASS., U. S. A.

E53
1929
(replacement 670357)

INTRODUCTION

MORE and more the world is turning to the physician to help it out of its troubles. If the physician is not to fail, he must infuse his professional interest with a wide personal interest in, and a caring for his patient as a person, and not look at him as merely an organism.

At first sight, this may seem far too narrow — this caring for a single patient, this apparently excessive loyalty to an individual. It really is not so, however, because every individual involves society. First, of course, comes the family. To save the patient not seldom means to save the family.

When the theory became generally known, that aberrations of sex, either structural or functional, were responsible for hysteria and even other forms of illness, there was an almost universal denial of its truth. Experience has shown, I believe, the validity of that denial. But there was a truth, I think, involved in the theory, though it seems to have been concealed from many. If for "sex" we substitute "personality," we may approximate more nearly, I hope, the whole truth in our search for the causes of some diseases and their possible cure.

Even if sex is involved in certain flagrant cases, it is more completely true, in my opinion, to refer to it as

one aspect of personality and personal relations than to do the reverse.

This is why it seems to me that such lectures as these on Physician and Patient are of inestimable value. They emphasize personality, the whole patient, including his family and home, his social and spiritual relations; and they also emphasize the necessity of taking them all into account in the study and treatment, not only of functional but also of organic and even infectious diseases.

Such ideas in the minds of mediocre men might not have much weight, deservedly, but, in the minds of men prominent in their profession and with international reputations due to their valuable contributions to society, they are worthy of the highest respect and deepest consideration, and that is why they are offered to all seekers after truth.

Just a word as to the origin of these lectures may be in place here.

Some years ago, through the help of a friend who wished to encourage the study of psychology as it pertains to medicine, and with the coöperation of the Dean of the Harvard Medical School, it was decided to inaugurate a series of special lectures on the personal care of the patient by the physician. This book has grown out of those lectures.

From the first the lectures were a success. This was principally because they were given by men of great eminence. But the time was ripe. For a long while

there had been growing a misapprehension of the nature and value of scientific study in medicine. These lectures showed, as was said by Dr. Francis W. Peabody, in one of the first lectures given and afterwards published under the title of "The Care of the Patient," that the trouble was not in being too scientific but in not being scientific enough. The patient had not only a body but also a mind, and a personality that should be taken care of in sickness. Dr. Peabody beautifully said, "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

Another reason that makes these lectures peculiarly timely is this: with the wider scientific study, especially through psychology, of diseases and patients, it has been found that a large number of cases apparently organic are really functional. This means that the only way of successfully treating them is through psychotherapy. Furthermore, if successful treatment is difficult, or impossible, the only way of even partially understanding such cases is through human sympathy and psychological analysis of the personality of the patients. This necessarily involves not only the care of the patient but also caring for the patient.

This book is intended for all who are interested in medicine. That includes, of course, physicians, nurses, students, social-service workers, and all who ever have been sick, ever will be sick, or ever have anything to do with the sick — pretty nearly everybody, in fact.

Its primary purpose, however, is to set the official seal of approval by the highest authority possible on the idea that a patient is a person, not a test tube in a laboratory, or an aggregation of organs, or a mere machine, and is to be cared for accordingly.

L. E. Emerson

Cambridge, Massachusetts
September 12, 1928

CONTENTS

I. Some of the Human Relations of Doctor and Patient 3
David L. Edsall, M.D.

II. The Care of Patients. Its Psychological Aspects 35
C. F. Martin, M.D.

III. The Medical Education of Jones, by Smith 59
W. S. Thayer, M.D.

IV. The Significance of Illness 100
Austen Fox Riggs, M.D.

V. Some Psychological Observations by the Surgeon 122
Franklin G. Balch, M.D.

VI. Human Nature and its Reaction to Suffering . 143
Lawrence K. Lunt, M.D.

VII. The Care of the Aged 175
Alfred Worcester, M.D.

VIII. The Care of the Dying 200
Alfred Worcester, M.D.

IX. Attention to Personality in Sex Hygiene 225
Alfred Worcester, M.D.

PHYSICIAN AND PATIENT

I

Some of the Human Relations of Doctor and Patient

By David L. Edsall, M.D.

In the fourth chapter of a book with the very prosaic title "English Sanitary Institutions," a book well known to health officials, there is a charming and forceful outline picture of the dominant rôle that monastic philanthropy took in the early mediaeval period in the care of the sick and unfortunate, and of the way in which it enduringly changed the conduct of the world toward the sick. In those times almost the only effective help or comfort that was offered to the struggling masses when they fell into illness or into more than the customary poverty and distress came from the orders of monks and their lay adherents. In its finest form it followed the influence of St. Francis of Assisi. Commonly before then the sick poor had been either neglected or looked after in a spirit of charity to inferiors. Through the mendicant friars it came to be kindly human devoted care. Their work in homes led to the collection of the sick where they could be ministered to better than could be done in the wretched surroundings that were perforce often their homes. Thus came hospitals, and from these, now, eight hundred years since St. Bar-

tholomew's was established, seven hundred years since St. Francis died, there has come a vast array of organizations for the care of the sick in institutions or in their homes, constituting one of the greatest of the world's activities and giving perhaps the finest evidence there is that the world shows some progress toward that time when poets will not write of man's inhumanity to man.

The above mentioned chapter ends:

> . . . in the Medical Profession, which counts technical skill to be only half of its fitting equipment, and which purports to owe heart, as well as brain and hand, to the service of even the least of mankind, we may reverently feel that, in those humane aspects, we inherit true light and leading from the ages which in science were darker than our own, and that Francis of Assisi, considered in his relation to the suffering poor, is almost one of the Fathers of Medicine.

Such was the light that guided the life of Sir John Simon, a man who devoted himself primarily not to the distressed individual, but to the collective community; and so effective was his work that he now ranks as one of the fathers of modern public health and preventive medicine. If in medical work for the community at large we must be led by the spirit that recognizes heart as well as brain, still more must this be true in caring for the single man. We may not forget that our inheritance in Medicine is in large part from those who, primarily engaged with spiritual affairs, nevertheless comprehended the dependence of the spirit upon the body. We hold this inheritance only in trust, and, concerned as we are with bodily ills, we should misuse it should we not

avail ourselves of the support that the spirit lends the body.

It may seem to some of you quite superfluous to dwell upon this through these special lectures. Like others who have chosen medicine as their life work, you have been much influenced in your choice by the fine opportunity that it gives for human service. With many of you this has largely determined your choice. Why then should you be reminded of what is already so important in your own minds. Why indeed should we offer you these lectures, which iterate and reiterate, as if it might be new to you, the very thing that is most in your hearts to do. If I may judge by what I have myself slowly learned and by what I have seen in many others, there is need of this in ways not yet wholly realized by you. All of us, teachers no less than students, do well to take heed of all pathways leading toward skill, not in technical medicine alone but equally in other aspects of our work.

My colleagues will take up special features of what we wish to present to you. I may be permitted to speak to you of some more general aspects. And, first, I would say that continually occupying the mind with matters of one sort tends to alter one's point of view, since it leads to the submerging of things that have once been uppermost in the mind by a mass of things of other sorts. Though not lost, the earlier visions then cease to determine one's thought and action unless aroused again by some stimulus. When you enter the study of

medicine you see at once that the desire to serve the sick, and even natural fitness for this service, are far from being adequate in themselves; that medicine has in the course of centuries accumulated an enormous amount of information and that this grows vaster year by year. In the past generation particularly it has increased in bulk and diversity in almost overwhelming manner. Altruistic purposes must be long and heavily chastened by acquiring an appalling number of facts, by training in a multitude of methods and by practice in the application of these, not in accordance with warm impulses of the heart, but with calm, precise, rather cool, analysis of their bearing upon each problem that is met. Florence Nightingale commented somewhat pungently upon the frequent, rather sentimental statement that nurses are "born, not made," and insisted that no woman is a born nurse; that whatever her gifts, she is a poor nurse unless severely trained. Even more is the doctor who is born not made, not merely a poor doctor: he is dangerous, and if he is not a conscious charlatan he is little better than the charlatan.

All the first half, most of the second half, of the medical course is devoted to acquiring facts and methods, to practising the use of them with precision, and to acquiring all the logical judgment one can in interpreting the results obtained in the solution of the differing puzzles that each patient, as well as each laboratory problem, presents. Without this, your ministrations to the sick

would be no service to them, but a menace, rather, to their lives or health. Among the multitudinous matters that must be within the knowledge of the skilful physician, you acquire even in this long and arduous process only part, and that part relates chiefly to things that are basic to the purely rational understanding of disease, its diagnosis, its control, and its treatment. Without this foundation the whole of the structure that you are building would be unsound. The things that make up this foundation are, however, largely the demonstrable, tangible, or measurable things. Directed they all are toward a humane end, but the personal human element nevertheless shows dimmer in the picture as time passes. The intangible and unmeasurable become so submerged in this constant current of what is capable of precise demonstration and proof that they tend to appear of inferior importance or to pass from the mind. Occasionally they even grow, not quite repellent, but uninviting, because not so subject to exact study. I have at times had intelligent students tell me that clinical work seems at first so inexact, so much in it is unknown, so much that appears to be successfully done by experienced clinicians cannot be passed on by them to others, so many judgments are reached for reasons not wholly clear when explained, that when compared with the comforting exactness and demonstrability of most of the work in the laboratories, clinical work appears unsound and intellectually unsatisfying. That they had such an impression at that period did not appear to me at all

discouraging. It seemed rather to show that together with intelligence they had the critical turn of mind that is so important in a clinician, and that they did not accept with mere docility what was offered them. The striving for exactness and soundness in the many inexact conditions of his work is a highly valuable trait in the clinician. Without it he quickly grows unsound and self-sufficient and may become little better than those without training. The attitude of these students was usually an inquiring rather than a contemptuous one, and most of these men, as they have penetrated further, have gone on to become peculiarly devoted and able clinicians. Nevertheless it showed that at the time they had somewhat drifted away, or perhaps had been led away, from the clear recognition that in clinical practice we do not deal with experimental animals or primarily with chemical or physical apparatus, which, difficult as they often are to control accurately, are still subject to a large degree of scientific control. Clinicians are, under conditions not subject to much precise control, engaged in the study of the most complex of all organisms, *homo sapiens*, a creature particularly distinguished by the fact that he has not only "a poor tender painful body," but also an equally sensitive and painful mind.

You recognize at once you begin to study disease that its actual physical aspects differ in each case of each disease; that any description, however clear or full, does not fit any instance entirely; and that in reaching

a decision as to the physical condition alone that is present, the most exact data we can secure do not ordinarily suffice of themselves, and the decision is finally dependent not only upon your knowledge but upon your judgment and insight. Whereas, however, each case shows physical conditions different from each other case, each patient has a different mind as well as a different body, and the mind may give a thousand shadings to each picture. May I remind you that the word "Commencement" is used in this country to indicate, apparently anomalously, the termination of the academic course, but that it really signifies the beginning of independent life work. With the medical course it is veritably a commencement, not only of life activities but of broader and more complex study and thought. That may sound discouragingly difficult, and it is difficult. None of us ever learn completely how to meet our tasks. Difficulty, however, adds greatly to the zest, and the most difficult part of all, the interpretation and aid of the individual, yields generous fruit for each effort in its study. Not only does it often render diagnosis and treatment themselves successful when either would fail if practised purely by rational methods — it changes each step in the work from a task to a human service. Instead of making the work suffer in the precision and accuracy that you have been led to feel are standards to be adhered to, it helps toward accuracy when purely rational methods, used alone, fail. I am told that in the first year of the great war, the food controller of one

enemy country calculated with much skill the food available and the food needed in that country and thereupon established what was apparently a thoroughly logical ration. He overlooked, however, one important thing, with the result that toward the end of the first year the ration failed and there was suffering and serious danger of grave disturbance of morale. The food controller was highly trained in nutrition, but he was trained as a veterinarian accustomed to dealing with animals that were both unthinking and unable to control their food supply. In this instance he was dealing with thinking and apprehensive human beings, and the peasants, who could control farm produce, hoarded it, and thus the amount apparently available was not to be had for distribution. Those who consider the medical course too scientific will at once think that this supports their view. On the contrary, it does quite the opposite. Had the food controller been untrained in the principles of nutrition there would have been not merely difficulty after months but chaos throughout. Beyond and above that, however, this incident showed merely that this official was inadequately trained in the scientific understanding of human nutrition. A thorough scientist takes account of all known variable factors, whereas this man, untrained in the study of the human being, failed to calculate upon the influence of the mind and provided simply fuel for a living machine.

Not only sympathy with but study of the man is not less needed than study of the manifestations of disease.

In this side of the doctor's work there is almost universal feeling that it is natural aptitude and sympathy alone that give skill. Some persons have, to be sure, greater gifts of understanding and human helpfulness than have others, but here again no one is born a doctor, and one becomes a master only through thoughtful and earnest effort. However comprehending you may be, you will meet an endless diversity of fears, sorrows, sufferings, sins and disappointed hopes, and these may both torment the soul and derange the body's response. Many a situation will be wholly new to you, for your own knowledge of the trials of life is, happily for you, thus far very limited, but you will need to know how in some degree to meet these many troubles for others. Increasing skill in penetrating beyond the body to the spirit of the individual comes not from kindly feeling alone but from pursuit of knowledge of individuals and of their traits and trials and from practised effort to aid them. It is often far less easy to dispel the spiritual disturbances of health than the physical, and it demands often a great deal more patience and insight.

Much of even the more concrete aspects of medicine cannot be given to others by teachers, but must accumulate through use of our training and our own individual powers of judgment. With things of the mind this is equally true. Something more trained and understanding than simple natural sympathy and more subtle than simple reassurance is required. Not doctors alone but any other intelligent persons recognize this.

Shakespeare felt and said it as completely as he did so many human things. In "Richard II," Bushy, concerned by the Queen's apprehensions, assured her:

> Each substance of a grief hath twenty shadows,
> Which shows like grief itself, but is not so;
> For sorrow's eye, glazed with blinding tears,
> Divides one thing entire to many objects,
> Like perspectives, which rightly gazed upon
> Show nothing but confusion; ey'd awry
> Distinguish form . . .

And thus, as with fear, so with suffering and other trials, are things often multiplied and eyed awry. But the mere assurance that this is true does not suffice to bring them back into perspective. The Queen responded:

> It may be so; but yet my inward soul
> Persuades me it is otherwise; howe'er it be,
> I cannot but be sad; so heavy sad
> As, though on thinking on no thought I think,
> Makes me with heavy nothing faint and shrink.

While, however, many of the ways of leading people to see things in true perspective are not given us by nature or by teachers, there are still somewhat open paths that we may follow to improve our powers of understanding and helping the multitude of different personalities and different human feelings that we meet. Among those that I would dwell upon one is a joy in itself and in many ways is of first importance, and yet it may seem to some to be quite aside from Medicine — intimate acquaintance with good general literature.

There is nothing that gives more comprehension of the varied psychological processes of humankind than wide reading, particularly of fine romance, poetry, and biography. It is a far better training in psychology than is the formal study of the subject, for the physician or for most others who are not to devote their lives to its technical aspects. The able novelist does much more than build up a story with a plot. He portrays character and the response of character to human experience, good and ill. He does not, of course, display openly that he is a psychologist. To label his work obviously as psychological studies would give the effect rather of a laboratory experiment than of a normal picture of life. Primarily nevertheless he is a psychologist. Turgenev said: "The writer must be a psychologist but a secret one; he must sense and know the roots of phenomena but offer only the phenomena themselves — as they blossom or wither." Later, also, he said to a young novelist in whom he was much interested: "The psychologist must disappear in the artist, as the skeleton is concealed within the warm and living body for which it serves as a firm but invisible support."

It is the best substitute for meeting them in real life to meet in literature a great number of people seen through the penetrating eyes of able persons whose chief preoccupation is study of people and of the ways in which trials and joys affect them. No one can in many years through his own activities alone meet such numerous and diverse characters and their perplexities

as can be met in this way in a few years. Nor does one ever meet many living people in such an intimate way, for the writer of fiction, of poetry, and of much biography puts in the open light, with an intimacy very rare in life, things that in life are kept in secret places and seldom disclosed. The poet indeed often uses a license in expressing his own feelings that would be almost offensive in an acquaintance and is in fact scarcely permissible in prose. Through knowledge of romance and poetry and of the lives of those who have made their lives worthy of record, not only does the reader become what we call cultivated — his very character broadens and deepens in ways that science alone, primary and imperative as it is to us, will not lead us to. In studies of life and of mankind one passes, vicariously though it be, through a wide range of those experiences and emotions that determine character.

And nothing aids more than a cultivated acquaintance with literature in lending the physician the social confidence and poise that relieve many embarrassments in trying situations, and that often lead quickly to the congenial relations so helpful in dealing with the sick — qualities that are particularly valuable in caring for those who have chronic illness. One may often observe indeed a depth of understanding and congeniality between those who have many mutual acquaintances in literature that is unusual in those who are unread. It is in part due, of course, to the pleasure that everyone has in simple mutual acquaintance; but in larger part

it is due to a quicker and more highly trained understanding and comradeship, a larger development of the spirit, that comes from having mutually had roused by writers many dormant interests and sympathies that the limited experiences of one's own life alone would not have wakened.

Naturally, however, books are but one source of enlightenment. In certain ways the powers of caring for human beings are most enlarged by close and observing contact with those who have become masters of the art. Seeing, much more than exposition, teaches the young physician methods of approach to people, the common barriers to knowledge of their feelings, the more frequent forms of apprehension and distress, and the human ways that bring healing. Those of you who secure opportunity for continued intimate relations with the actual work of one or more practitioners who have trained and elaborated their own gifts will all believe subsequently that no other guidance has been more helpful to you. Too few do this now in the homes of the sick. The days when men became doctors in large part through apprenticeship were days of very faulty training, but as Simon said in the words I quoted from him: "We inherit true light and leading from the ages which in science were darker than our own." There were features in the training at that time that the purely institutional course of recent days lacks. A partial revival of the apprentice system is even now appearing in several schools of medicine and in a form better than

any yet devised, I believe it will become enduringly grafted upon the modern course.

Although it may seem trivial to you, I am tempted to comment upon one pitfall in such experience. A not inconsiderable number of those who have followed a master of medical practice admiringly come to ape his methods and mannerisms quite directly. Mere imitation rarely succeeds and is unimaginative, and it carries with it a strong suggestion of unreality and insincerity, if indeed it does not become a little ridiculous. Stevenson said that the attractive style his writings show was gained by long hard work, observing and imitating the style of other writers whom he admired. But he so fused what he had gained from others into his own gracious personality that in the end it was not imitation but his own. It is not through playing a rôle but through offering our own selves, trained and ripened through the experience of others, that we can gain personal power to heal.

Nevertheless, through others who are more skilled we come rapidly to see our errors, and our crudities in understanding and adroitness, and although the multitude of human personalities is so diverse that we cannot learn them individually through rules or by merely following the example of others, but must study each one for himself, we do learn quickly that there are a few things so conspicuous in all human kind that it is needful to hold them in mind in every relation with patients.

A few of these I can lay before you and leave their

elaboration to your future thought. Chief of them is the element of fear. Most persons who have reason to consult a physician are apprehensive, often intensely so. Some fear death, sometimes they are in special dread of suffering, or of disability, sometimes it is the mere association of doctors, and the need of their advice, with death and grave disease that rouses undefined fear. Even in relatively trivial things they are often apprehensive. More often than not their fears are groundless or exaggerated, but they are nevertheless potent to distress them and to color the picture they give you of their ills. And very frequently indeed their apprehension is greater than the surface would show. With wage earners fear of hardship for those dear to them in case they become incapacitated through illness often dominates their minds. This is quite apparent to others than doctors. Mackenzie King, the premier of Canada, a conspicuous student of industrial relations, recognizes this at length and with much emphasis in his book, "Industry and Humanity." He dwells upon the undercurrent of fear of illness that even in health sways those who work for a wage, and rates this indeed as one of the most important elements in producing great labor difficulties, a sufficient evidence of its frequency and its influence.

Patients in hospitals are more generally apprehensive and more often intensely so than those in private practice. The very word hospital connotes a fearful place to many, especially to simple people, and to enter a hospital as a patient is, to a large proportion of people,

a great ordeal. The unhomelike surroundings, the apparatus, the consciousness of many others being gravely ill there, the obvious and perhaps noisy suffering of others, all these and other things heighten preconceptions or arouse fears if they were not present before. The quiet controlled way in which most hospital patients take their introduction to what must often be at first an intensely harrowing experience is a matter of wonder to me when I attempt to feel it as they must. But it takes indeed a conscious effort to put ourselves in a patient's place and we cannot ever fully succeed. All who are engaged in medical work, whether graduates or undergraduates, may well ponder upon some of the written expressions of the feelings excited by things we have grown accustomed to when these things are met, not by those who are interested participants in the work going on, but by lonely apprehensive victims of suffering. Henley's verses, "In Hospital," inspired by his own experience, give a well-known picture of the unfriendly bare walls, the weary waiting for admission, the suggestive dressings and apparatus, the preparation for operation, the casual way that the hospital personnel often carry through things that stir the nerves of the observing patient, the sufferings of others, and the anxiety and depression roused by all these things. For the general reader these verses have a shade of gloom. For the physician they are helpful in leading him to think back to the days of his technical ignorance. Of the many bits of the picture that he gives let me read you the first two:

Enter Patient

The morning mists still haunt the stony street;
The northern summer air is shrill and cold;
And lo, the Hospital, grey, quiet, old,
Where Life and Death like friendly chafferers meet.
Thro' the loud spaciousness and draughty gloom
A small, strange child — so aged yet so young! —
Her little arm besplinted and beslung,
Precedes me gravely to the waiting-room.
I limp behind, my confidence all gone.
The grey-haired soldier porter waves me on,
And on I crawl, and still my spirits fail;
A tragic meanness seems so to environ
The corridors and stairs of stone and iron,
Cold, naked, clean, half-workhouse, and half-jail.

Waiting

A square, squat room (a cellar on promotion),
Drab to the soul, drab to the very daylight;
Plasters astray in unnatural-looking tinware;
Scissors and lint and apothecary's jars.

Here, on a bench a skeleton would writhe from,
Angry and sore, I wait to be admitted;
Wait till my heart is lead upon my stomach,
While at their ease two dressers do their chores.

One has a probe — it feels to me a crowbar.
A small boy sniffs and shudders after bluestone.
A poor old tramp explains his poor old ulcers.
Life is (I think) a blunder and a shame.

When one has in any form of work gained special knowledge not common to others, he has crossed the Rubicon. While he has thereby gained a new kingdom,

he has at the same time lost the view that he had from the other side and only conscious effort can bring it back. Possession of technical medical knowledge carries with it intimacy with many things that are fearful to those who are not thus informed. To those who know them well, even the truly alarming things arouse less of fear than of composed recognition, while with those things that have no essential dangers but seem to have only because of ignorance, familiarity tends to breed contempt. We need to have some care lest the knowledge that drives away unfounded fears from us harden our understanding of those who still have such fears.

I have said that constant training in things of the reason tends to obscure somewhat the view of things that are emotional. When entering their clinical work, most groups of medical students have become so habituated to the impersonal aspects of the training that for a time they have, I think, less acute comprehension of the conditions surrounding them which may distress the sensitive than they had when they came into the school.

Some of these may at first thought appear very trivial. Buzzing conversation, laughter and other carefree noises are for example not only harmless in this room when waiting for a lecture, they are rather spirited and agreeable for the instructor to listen to from round the corner. When, however, round the corner are sick people waiting for that strange experience of being the subjects of a clinical lecture or demonstration, the effect is wholly different. When carried through with order

and quiet and simple reassurance, appearing in clinic is not usually a tax upon people, but it is often pleasantly diverting. But when upon approaching the lecture room they hear sounds of a crowd out apparently for a gala occasion, they often change countenance at once, and not uncommonly imagine horrors ahead that to sick quivering nerves equal those of a real "bull-ring." Repeatedly when they first heard the careless noises from a lecture room, I have had them beg, suddenly and tremblingly, to be taken back to the wards. I do not for a moment suggest that this is callousness on the part of the students. It takes only an explanation of what noise and disorder mean to make the waiting for the next clinic quiet and comprehending.

Again, it is not rare, with internes especially but also with those who are more experienced, preoccupied with pressing anxieties, to mention within earshot of the patient uneasy thoughts that are not yet ripe for judgment and are merely thoughts with them, but that in the mind of the one most concerned at once become fearful prospects awaiting him. These are only instances of what in varied ways is true throughout the lives of physicians, the need to strive to see ahead the responses that patients are likely to make even to slight words or acts,when apprehension is often their dominant feeling. The avoiding of these things cannot be properly learned through error alone. We make errors and slips enough at best and they teach us much, but as a method of training, error is to be minimized. Some of your errors

will follow you in your thoughts long afterward, especially when you find that fears which appear to be due merely to loss of self-control prove to be more subtly true than your judgment, complacently relying upon demonstrable signs, has led you to perceive. When I was an interne a girl of eighteen was admitted with what was apparently simple hysteria, but was certainly very exasperating and very disturbing to the other patients. She appeared to be most ingenious in inventing annoying practices. The night after she came in I was called because she had got out of bed, was on the floor in a corner, and was loudly and tearfully protesting that she was paralyzed and could not get back to bed. After assuring myself that she was not paralyzed, and other means of quieting her failing in a most irritating way, I gave her a pretty intense charge from a faradic battery. Thereupon she quite graciously said that that had made her well, got up spontaneously, and walked back to bed. I then isolated her where her tears and screams would not disturb others, and for two days I spent my time on others who had I thought real things wrong with them, and a little scornfully rather neglected this girl. Two or three of my teachers were partly responsible for this, for I had absorbed from them a somewhat clear conviction that neurotics and hysterics were not cases for a real doctor to bother with but had best be palmed off on neurologists, an attitude that now is thought less intelligent than some persons in those days held it to be. My chief had been absent. When he returned and

examined her I was disquieted by his expression, and I am still disturbed by his prompt recognition that she was then paralyzed, that she had acute myelitis and had but a few days to live. It taught me very severely that neurotic and hysterical symptoms are not infrequently precursors, or direct manifestations, of grave organic disease. It was not a far thought from this that, even when no organic background can be found for such symptoms, this shows only our ignorance and is not a charge against the patient's character. It became far easier too, to see that those who have no organic disease behind their psychoneuroses often deserve patient help still more than those who have. The latter frequently recover or die soon, and, too, can often be given concrete help. The others usually go through a long dreary time, perhaps a dreary life, unless relieved by very patient and painstaking attention; and this not uncommonly means that the doctor must carry both them and their burdens until they get on to more solid ground. One evening before he went to England to live Dr. Osler gave an address in Philadelphia where I then was. Afterward he walked with me and another young physician to one of the clubs. As we were entering the door, my contemporary was led to say a little contemptuously that it seemed a pity that a certain physician, who was the son of one of the greatest men in American medicine, should not make more worthy contributions to Medicine. Osler never tolerated such a viewpoint nor did he tolerate unnecessary criticism. He caught

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the man by the collar, swung him round to face him and said: "Young man, if when you die you have done half as much good as that man has in patiently carrying hundreds of neurasthenics back to health and happiness, you may be grateful."

Undue fearfulness, too, is not merely distressing but at times is even of serious influence in determining a fatal outcome. I have seen many persons with typhoid fever or other important acute disease, especially foreigners who could have but little speech with their doctors and who were ignorant and superstitious, who had a look that haunts me still, a look of blank and utter hopelessness; and often even in the very early periods of the disease, when they were not especially ill. I particularly recall among the hundreds of cases of typhoid fever that we had each year during my service at the Episcopal Hospital in Philadelphia the Polish laborers, strong men usually but often filled with overwhelming fear. So common was this look of terrified expectation of death among them and so potent the effects of their attitude, that the internes had a tradition that a Pole with that look always died. But in lesser disorders a fearful pessimism will often go far to determine the existence of symptoms, the duration of a disorder and even its outcome, whereas courage and optimism not only render the sufferer more serene, but are also powerful allies to the doctor in a fight.

In any case fear is a dread thing to live with, and in some degree it is as commonly present as anything you

have to deal with. Little as well as big things that the physician does or says, slight gestures even or a stray word, may inadvertently precipitate fear, or they may help to dispel it. You have to overcome your natural modesty to the point of believing that the distracted mind of your patient often makes an oracle of your words or acts. One of my friends, a rarely brilliant young woman, had a long depression psychosis. She afterward told me that early in the attack her physician, a rather stupid man, seeing on her table a bottle of Fowler's solution that he had prescribed some months before for a mild anemia, told the nurse in her hearing, in a distinctly impressive manner, to throw it away. As the patient long afterward said, the dull-witted man did not see that her mind flew at once to the idea that he feared she might commit suicide. Never before had she wished, as so many others have with Hamlet wished, "that the Everlasting had not fix'd his canon 'gainst self slaughter"; but subsequently for months the doctor's luckless exposure of his thought made suicide appear to her a thing ordained, and the obscurity of the undiscovered country seemed a welcome release from the darkness she was in.

The only dependable guides that we have in our difficulties are courage and optimism. We need to seek to be worthy of that gracious though all too generous preface to "Underwoods" and to attempt to carry to others as physicians the spirit that its sweet-natured author carried to his readers, and most of all perhaps to

his physicians, throughout his long-drawn and depressing ill health. It runs in its earlier part, as some of you well know:

> There are men and classes of men that stand above the common herd: the soldier, the sailor and the shepherd not unfrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing.

On one of my visits to Johns Hopkins I made the ward rounds with Osler and his students. We spent a few moments at the bedside of an advanced gastric carcinoma, and as we walked on, Osler with characteristic mixture of whimsicality and seriousness suddenly caught the arm of the student and said: "Tell me what can put forty pounds on a patient with cancer of the stomach?" Hopelessly puzzled, the student said he did not know. "An optimistic consultant," said Osler. "William Pepper could do it every time, could n't he, Edsall?" I had the rare fortune to be an assistant of William Pepper. I have met no mind more brilliant, none in Medicine so swiftly penetrating, nor have I known

any man abler in diagnosis or therapeusis. He was head of the University of Pennsylvania and, too, Professor of Medicine there, head of the Philadelphia Free Libraries and of the Commercial Museums, and an influential director in several great corporations all at the same time, but he had also a very large practice from all over the country. I have never seen a man live under such driving pressure, a pressure that killed him early; but with all the distractions of his life I never knew Dr. Pepper to neglect to give every one who needed it a word of cheer and a stiffening of courage, and with a gracious charm that no one who met it ever forgot. Doctors often spoke of the brightened outlook that even patients with hopeless disease had, frequently for weeks, after a single consultation with him; and yet for the last few years of his life he often suffered intensely and throughout that period knew that death was at his elbow. I was temporarily in charge of his office when his end, wholly unexpected to most people, came suddenly. I see now the stunned look of those who came in; and at the funeral service, occurring in mid-summer when that city is ordinarily almost deserted, of the great numbers present many were openly in grief. It was the thought of the burdens that he had taken from them more than the loss of wide public service and keen diagnostic and therapeutic skill that moistened the eyes of that gathering. When special pressure has tempted me to feel that the drive of work left no time for these things, this example of my early chief has come frequently to mind.

It is often asked whether the patient who is or may be gravely ill should be told the strict truth — whether a spirit of encouragement is not often wrong. One of the most certain ways of losing the confidence of patients and thereby of losing power to help them is to give them reason to think that they can not trust your reassurances. There can be no real question, I think, that the truth should be told when you are reasonably sure of it and when patients wish it, even though it be oppressive. But this is not a matter to be settled solely on cold and abstract moral grounds nor can the truth be presented merely as a result of reasoned judgment after consulting the theory of probabilities. It is first to be remembered that with our uncertain knowledge and skill it is extremely difficult in very many instances to be at all sure what is true. If there is reasonable doubt it is quite wrong to tell patients depressing possibilities or even probabilities. Probabilities often fail most disconcertingly to come about, and in such cases to have led a patient to expect suffering or disability or death is to have given him great distress in consequence simply of your own error. It is likewise to be remembered that the truth, expressed as your medically trained mind sees it, may be far from the truth to the jaundiced mind of a patient. Many things will be exaggerated by him beyond what they mean to you and will become fearsome unless your statements are carefully tuned into accord with his view of them.

And when distressing things must be told it is essential to keep in strong relief in your minds that moral as well as material fibre may give way under great strain encountered suddenly in full force but may take the same strain without break when met gently and slowly. The prospect of death, of prolonged disease, of suffering, or of incapacity rarely needs to be painted with one stroke, if pictured it must be.

And there are other things than these that may be no less distressing and fearful when met suddenly. I still see clearly the simple little house on Lombard Street in Philadelphia where I first had occasion to tell an unmarried girl that in a few months she would be a mother. I still shrink from the torrent of anguish that came from her and her mother, owing in part to the clumsy way in which I broke the dam to their emotions. It was a rather puzzling case and when I had assured myself of its nature, preoccupied by the diagnosis, I answered their questions not roughly but rather directly. I saw at the moment chiefly the diagnosis, but I made them see with startling suddenness and with overwhelming reality what she at least had feared before but had feared only in secret and trying to disbelieve her fears, that at twenty she was entering a dreary pathway darkened throughout life by shame.

Happily in most instances when things that are dreaded must be suspected or known by patients there is still a thread of hope. Whatever your consciences may tell you about complete truthfulness, this thread, how-

ever tenuous, may almost never be broken without unnecessary cruelty. Again we must remember that we are liable to error, and to take away hope in the absence of actual certainty is sheer brutal stupidity. Fortunately almost every one has enough of the simple gift of sympathy to perceive this, but occasionally one meets strange instances of ruthless wiping out of hopeful doubt. I have in mind, for instance, a patient who consulted a physician who was then one of the most distinguished of the profession but who always liked to be thought something of a wizard. The patient was vaguely fearful of serious disease, but was utterly shocked and unnerved when the physician, feeling a mass in the abdomen after a moment's examination, said, "How long have you had this cancer?" It apparently was cancer, but another physician, uncertain of its nature, took a chance and reassured him. Years later the mass was still there but the man was quite well. I might recount other less brutal but equally positive insistence with patients that they must prepare for death, when that really seemed likely, though by no means certain, and then Death proved to be far away.

The few instances that one meets of this are likely to be due to a quite unadmirable feeling that very positive statements by the doctor will seem to show force and confidence, even though they do perhaps hurt. You will often enough have to see doubt disappear and to admit that hope is gone. Those particularly who become medical consultants will find, as in other occu-

pations, that while there are certain sides to this work that are enviable, there are some that are unhappy. Among the sorry things you will discover that in a far larger proportion of cases than is true of the family doctor, the consultant, acting as the court of last appeal, has to plunge patients and family into

> The breaking gulfs of sorrow
> Where the helpless feet stretch out
> And find in the deeps of darkness
> No footing so solid as doubt.

Even in such extremities, if a bit of wreckage can be found for a time, it may be a frail support, but it does while it lasts, as Lowell indicates in those lines, give the helpless feet some sense of support.

And after hope is gone, if the end is not yet upon us, we still have helpful service to be done. One of our poets whose verses, melancholy though they often are, are filled with a sort of beauty and insight that has rarely been reached by others, muses upon the loneliness of sorrow, the wistful sense of remoteness from those who are not in grief, that is common in those who are passing through deep sorrow. A similar loneliness is very common in those who are ill, especially in those who are very gravely ill. Even those whose lives are not in danger, but who suffer or are disabled, who lose their sight or their hearing, or who are otherwise handicapped, are frequently burdened by heavy loneliness not merely because they are separated from their activities and their friends, but in great part because they become,

or feel that they have become, separated from the live thoughts and interests of those who are well. Romola's sightless father said to her:

> For blindness acts like a dam, sending the streams of thought backward along the already travelled channels, and hindering the course onward.

To those, however, whose path lies in the shadow of death there comes often a great loneliness in their journey and a yearning for a comrade along the way. Because the doctor, accompanying those who are to go on through the Valley of the Shadow, has often penetrated deeply therein, he seems frequently to patients to offer such comradeship and such confidence and guidance as can be given. Thus even when his physical ministrations have ceased to provide hope of more than passing ease, he still has strong help to give. In return he will find that he receives from many who are about to cross the bar, gifts of the spirit that will be cherished among the great treasures that his work yields him.

Such, gentlemen, are some of the marks that I have found along the trail that leads to the end we seek. You are on the same path and you will find that from matters that are insignificant to those who are desperate the man as well as the disease bespeaks thought and concern. There may seem a sombre tint to much that I have dwelt upon, and indeed there is much that is grievous in the life of the physician. In times of pressure one hears all too clearly the plaintive strain, like the waves of Dover Beach,

Begin and cease, and then again begin,
With tremulous cadence slow, and bring
The eternal note of sadness in.

But do not let me lead you to fear that the prevailing tone of your lives will be dark. Most of your work will have no threat of tragedy, and though for a time there is frequently apprehension, serene and happy issues are far more common than the sad. And even the sorrowful experiences that every physician goes through are far from being a regrettable part of his work. President Patton, of Princeton, told us once when I was a student in his course in Ethics that a young man who was brought up carefully shielded from all the evils of the world might pass as a moral person, but to his mind he had the morality of a clam. And so the person who has not gone through, for himself or others, periods of distress and anxiety and even gloom, has only the visions and emotions of a clam. Unrelieved sunshine does not bring out, it obscures, the greatest beauties of color and outline. I first saw the Grand Cañon of the Colorado in brilliant midday sunlight and saw it with a distinct sense of disappointment except for its vastness. Only when the shadows began to come were there really visible the marvellous colors and shapes that make it one of the wonders of the world. And just as it is only through contrasts that one can appreciate either physical or spiritual beauty and the satisfaction that comes from them, likewise it is only through knowledge of great trials that one sees the

real happiness that they contrast with. Only thus also does one gain the comforting sense of usefulness to others in times of trial. The material recompense of the life of the physician is for most not large, but we may confidently feel that no life offers more intimate and varied views of the beautiful; and the most satisfyingly beautiful visions are often seen when riding through the storm of a great tragedy, and no life offers more of the satisfaction that comes with service. There are those who protest, and we may well think with justice, that the material recompense is commonly too little return for the effort that the physician gives. But the recompense in beauty and in satisfaction that is so much greater than that from most other work is found chiefly when it is recognized that we are ourselves in some degree paying a debt in this part of our work, not making a gift; that, in Sir John Simon's words, we belong to a profession that purports not merely to give but to *owe* "heart as well as brain and hand to the service of even the least of mankind."

II

The Care of Patients.[1] Its Psychological Aspects

By C. F. Martin, M.D.

I NEED not say with what appreciation I received the courteous invitation to visit your great School, or with what pleasure — not unaccompanied by embarrassment — I have accepted the privilege of addressing you. To the Harvard Medical School and to Boston have been accorded, more than to any other institution or city in America, the credit of advancing community relief of human suffering and sociological enterprise. Harvard, the academic dwelling of Oliver Wendell Holmes, great among physicians, whose life and scientific attainments wielded so mighty an influence on his fellow men; Boston, the city where, under the aegis of Richard Cabot and Joseph Pratt, social service on an organized scale had its inception and where the home treatment of tuberculosis gave health and hope to so many afflicted. These were pioneer undertakings on this Continent, and blazed the trail for all future endeavour of the kind. Nor can I refrain from mentioning Dr. Worcester, whose efforts on behalf of rural cottage

[1] An address delivered to the students of Harvard Medical School on November 1, 1927.

hospitals and community nursing have rendered such fruitful service. It is, as it were, bringing coals to Newcastle to enter your domain with any suggestions as to the human care of the patient.

I have read with great interest the informing and inspiring lecture delivered at this School by my friend, the late Dr. Peabody. As one reads his address, one hears his sympathetic heart beat aloud. His was a life in which the humanitarian principles he taught were exemplified, for the basis of his work was CHARACTER. Through all the splendors of his active administration, through all the glory of his scientific work, there breathed a faith that inspired every action of his life, every moment of his day. His honesty of purpose, his humility, and his unfailing sympathy drew all hearts, willingly or unwillingly, to him; and the example shown in the closing months of his career will long be remembered by his colleagues and friends.

I congratulate you on being students of this School, justly celebrated for its noble traditions, its long list of eminent teachers and graduates, its marvellous record of academic achievement, and above all, its noteworthy advancements of recent years initiated and so ably maintained by your present Dean.

You have asked me to talk on "The Care of the Patient" — the human being afflicted with disease, rather than on the scientific problems of diagnosis and cure; and so I take as my topic the *psychological aspects* of that care. And yet in the very human care of the

man or woman as such, there lies latent the very essence of science — the study of the nature of the individual, his psychology and his psychopathic weaknesses.

I take it that in your University, as in ours, — thanks to the ever-increasing demand for knowledge in the study of disease, — there is a tendency in instruction to neglect this very human side through lack of time. One projects before your eyes mainly the pathological and chemical pictures of disease. Nor can one blame you as students if, after all your meticulous care, you are satisfied to a finality by the successful achievement of a diagnosis — more especially if the case be one shrouded in mystery or obscure beyond ordinary ken. And inasmuch as the curative treatment of many advanced diseases is at times elusive, you will remain content with your success, register the diagnosis and watch with equanimity your patient's departure from the hospital. In bidding him farewell, you may even provide him with a bottle of medicine and enjoin him to return one month hence for further tests. You will, indeed, do even more, and caution him against overwork and an inadequate diet, and perhaps suggest a sojourn in other climes. In this well-organized community, too, you will no doubt follow up the patient through the agency of your social service, and send someone to the home with helpful suggestions and practical advice, and report to headquarters with a record of the findings. Beyond that, I fancy you do not usually go. There is scarcely opportunity in your busy life, for you are learning the essen-

tials now, and you await your graduation to practise the healing art. But how much further you will persist, how deep your insight into human nature, how close a contact you establish with your patients will depend, in part, on your early bringing up in the home, on your personality, patience, tact, and the interest you take in human service.

That there should be indifference on the part of physicians to the human side of a patient's care has sometimes been attributed to our system of education. Is it any wonder, they say, that our students, with an overcrowded and exacting curriculum, have little time to devote to these accessories of medicine — environmental influences of the sick, their worries and anxieties, their hopes and fears? But, after all, it surely is not a question of time. They have all the time there is, and with Arnold Bennett, could use their twenty-four hours a day with greater profit. This presumedly trivial adjunct of medical practice is, moreover, a fundamental principle of treatment that has lasted through the ages; a psychological one, if you will, and one whose basis is suggestion.

The power of *suggestion* is as old as history, and its effects are recorded throughout the ages since the world began. Though the technique varies, the cult is always the same. The healing of the mind and of the body in one form or another is common matter of ancient and modern practice, and the subject — in scientific or quasi-scientific form — fills the literature.

It is a far cry from Imhotep, that earliest of physicians, to the modern shrine of Notre Dame de Lourdes; 6,000 years have rolled by since Imhotep, the medical guide, philosopher, and friend to the Egyptian monarch, practised his art. Preëminent in wisdom, in magic, and in medicine (note the combination), he not only healed men of their ills but cared for them in their journey after death. Later we find him proclaimed a god, and later still known to the Greeks as the mythical precursor of Æsculapius. You are all familiar with the Temples of Edfu and Isis, with the Æsculapian shrine on the isle in the Tiber, with its votive offerings, its sacrificial ceremonial, and hygienic facilities for the cure of disease. Priest and physician at that time were one, for out of the spiritual protoplasm of magic, there evolved the physician, philosopher, and priest. And ever side by side were demonological conceptions and simple surgical practices, magical therapies and herbal lore.

So it is even to this day — six thousand years later — with Our Lady of Lourdes; for verily, as if by miracle, as if by the laying-on of hands, the lame are made to walk, the blind to see, and the deaf to hear — and never a question of the mandate, never a doubt as to the diagnosis or means of cure, never a question as to whether it be scientific or religious healing.

As we travel down the centuries, history continues to repeat itself; and so we see on the one hand reputable physicians, and on the other, irregular practitioners of cults and quackery, competing side by side in

the treatment of disease, each with his own success and failure.

He who goes about doing good is a physician of the body as of the soul, and those with a scientific training who can utilize a knowledge of human nature attain the goal more readily. Plato it was who said, "The office of the physician extends equally to the purification of the mind and of the body; to neglect the one is to expose the other to evident peril. It is not only the body which, by a sound constitution, strengthens the soul, but the well-regulated soul, by its authoritative power, maintains the body in perfect health." *Mens sana in corpore sano.* Galen, too, emphasized the care of the soul in the treatment of disease; while Celsus urged upon doctors to be friends to their patients.

Conspicuous in later times among the great advocates of suggestion and mental treatment was Paracelsus, the Father of Modern Chemistry, the discoverer of bismuth and of zinc, the inventor of laudanum, the advocate of transfusion, which he practised, and the friend of humanity. A man of parts — of scientific knowledge and technical skill — without reverence or wisdom; the arch-charlatan, too, of his time, for he claimed power over death and a cure for all diseases; his sympathetic salves and powders ultimately sounded his doom, for he assumed more than he knew.

It is interesting, however, to note his dualistic conception of the healing art: — "There are," he says, "two kinds of physicians, those who heal miraculously

and those who heal through medicine. Only he who *believes* can cure by miracles, and the physician must accomplish that which God would have done miraculously had there been faith enough in the sick man."

Paracelsus, whatever the verdict of history, was a friend to his fellow-kind.

Suggestion as a form of treatment, then, had largely been preëmpted by the field of irregular practice, while the more or less scientific and rational physician seems to have passed it by as the idle wind which he respects not.

None the less, to the lay mind there *ever* remains, in matters medical, something of the occult — the mysterious; and man has not up to the present day quite lost his belief in the efficacy of magic.

But Science is advancing rapidly, and within recent decades Psychology has at last emerged from its academic quiet to a place of great and practical importance.

The introduction in the eighteenth century of the theory of magnetic force as a power to cure disease brings us nearer to the modern conception of psychopathology, for here the *personal* influence of suggestion becomes a real therapeutic factor. You will recall how Mesmer, in 1766, introduced his theory of magnetic fluids, upon the distribution of which, in the body, depended health or disease, and the course of which could be altered by the will of another person. The technique employed in his Paris clinic for treatment by animal magnetism recalls the Arabian Nights. In semi-darkness

or under subdued and coloured lights, and to the strains of soothing music, patients were seated around a common magnet or tub awaiting the master's approach. In this tub were chemicals, iron filings and sulphuric acid, or what not. From its sides there protruded iron rods, whose ends made contact with such parts of the patients' bodies as were affected. Finally, with the stage all set, enter Mesmer, clad in lilac robes, head thrown back, eyes staring, with all the solemnity of a prophet; and so, passing from one to the other, with stately mien, touching one with his wand and another with his outstretched hand; no cures without the personal contact of the magician! The results would vary — in some cases hysterical convulsions or trances; in others a genuine cure. The vogue once established gained ground, and for a long period the cult received approval from the intelligentsia.

Later literature from time to time gave added emphasis to this great principle of psychological influences, and the works of Le Camus on "Medicine of the Mind," and Feuchtersleben on "The Dietetics of the Soul" bespeak a serious interest in the problems.

I have already said that in ancient times physician and priest were one, but although for several thousand years, rational medicine had been freed from the Church, it appears to have left to Theology the care of the much-disputed soul, and controversies were common enough.

To-day, however, we see a tendency on the part of the Church to reverse its earlier antagonism to Science, while Science for its part is more ready than ever before to enter the speculative fields of psychology and philosophy.

Do not forget, however, that the Church has never quite abandoned its claim to healing, as witness the successes of Our Lady of Lourdes, and our Brother André of St. Joseph, whose shrine at Montreal attracts millions from your great country to the South. Surely one must see in these great successes at least some defect on the part of the medical profession, a defect apparently not unobserved by the Church!

Conspicuous among the proofs of this desire on the part of the Church to enter the field of Medicine in one way or another is the recent action of the Church of England. After three years of deliberation, it has formed a permanent advisory committee of clergymen, doctors, and psychologists, to consider ways and means of meeting human needs. More recently, I am told, the Episcopal Church of America has followed in its wake.

It is unthinkable that the medical profession alone has neither idealism nor the capacity to carry on this great work. Is it, however, for this reason — beyond all others — that there have grown up the numerous organized bodies, indulging in religio-therapeutic service? Such, at all events, may explain to some extent the unparalleled success of Christian Science, with its 1,500,000 members, its 7,000 practitioners, its audiences

of 2,500,000 persons per annum. So, too, the less conspicuous success of Jewish Science, Mental Healing, Divine Science, and all the other cults, religious and non-religious, found in every English-speaking community. In one and all of these forms of therapeutics, there is a close resemblance to the so-called miracle-therapy, the same disregard of scientific diagnosis, the same ignorance of the specific etiological factors, and the same uniformity of treatment for all diseases. The healing power, largely through suggestion, built upon a kind of religion and quasi-philosophy, supplies to the patient the spiritual power necessary to some men's needs, and to others, a therapeutic agent of great potency. Within the fundamental error of its doctrine is a germ of truth, which every doctor would do well to recognize. The advocates of the cult do not labor entirely in the dark, for they realize the healing force to be the human mind. No longer is it an appeal to the occult, but to the power of thought within oneself. The kernel is the spirit of optimism, the suggestion that you rise superior to your contemptible malady, conquer your fears, worries, and doubts, relying on the efficacy of courage, hope, and trust. Pessimism leads to weakness and optimism to a cure.

The fallacies of the cult, to which I will not refer, are obvious to every reasoning man of science.

You will recall the story of Mark Twain's experience with one of these cults, — a caricature, it is true, but, nevertheless, substantially just. Having been presum-

ably placed under treatment by one of these religious healers for fractured bones, he is told that there is no such thing as pain, and that his symptoms are but an expression of his imagination, and he asks: "Does nothing exist but mind?" and the answer comes back, "Nothing." "All else is substanceless?" he asks. "Yes, all else is imagination." Whereupon he says, "I gave her an imaginary cheque, and she is now suing me for substantial dollars."

Needless to say, the outstanding realities of illness, and death are not shuffled out of the world by the mere denial of their existence. True also it is that those who fail to see these evils and their dangers are like the ostrich who puts his head into the sand to avoid the sight of evil.

The wisest psychology will never replace quinine and mercury in the cure of certain diseases, nor can it obviate the necessity of operative procedure for a perforated appendix. Treatments — psychological or otherwise — which are formulated without benefit of a diagnosis or careful examination, are not without danger. That many benefits, however, are conferred on the more fortunate adherents of these cults is not to be ignored — benefits, however, which should not be the property alone of the untrained mental healer, but are in reality in the possession of every practising physician, of every man with a human interest and an adequate appreciation of the needs of suffering humanity. Do not forget that every organic disease has its functional side, and

its discomforts of mind and body. Change the outlook in anybody with organic disease and improvement is possible — not alone in the mental attitude, but in the physical condition as well.

To the patient with cancer of the stomach may come improvement in the appetite and a sense of well-being; to the advanced tuberculous patient hope gives added strength. Encouragement to the diabetic makes him walk better; and with proper psychotherapy, even the hemiplegic learns the use of limbs which hitherto he has believed to be immobile. (In this connection I may refer you to the very remarkable instance reported by Hurst to the Royal Society of Medicine in 1919.)

The mental healer, then, gives peace and added hope, or, in the more serious cases at all events, a philosophical submission to one's destiny. He offers education to remove the veils of doubt which obscure the vision of a possible cure; he teaches the patient that he lives a life of his own making, an adjustable one if only there be coöperation with the spirit behind. "I don't know what it is," said one patient with a chronic nephritis to his doctor, "but from the first day you took charge of my case, I have felt better"; and the doctor had made no essential change in the specific treatments!

"Do not fear," says the healer; "do not rebel; do not complain, and you will have a simple system of conduct that will shape your life to one ideal, and you will feel better. You are impatient to get well, forgetting that there are natural laws of recovery which require

patience. When you cease to look upon any experience as too hard, you have advanced just so much in your adjustment to life."

"Talk Health," say others, "and keep smiling at your symptoms of disease" — a constructive technique which permits no thought of discomfort or of illness.

So much for some of the benefits of this remarkable technique — all the more remarkable because of its use by untrained, uneducated, untutored laymen. Needless to reiterate that I do not like the extravagant assumptions which record these mental gymnastics as a panacea for all ills; which, geographically speaking, cure everything from quinsy to haemorrhoids, from a sprained ankle to a fractured skull! Most of these assumptions offering a cure for organic disease are based upon faulty observation, or an inaccurate diagnosis, or have failed to make allowance for the *vis medicatrix Naturae*. On the other hand, there is no good ground for ascribing to pure chance *all* the cures enumerated by the healer. Indeed, if you only realized it, these seeming miracles are matters of daily experience with our own physicians who practise the method. Take the common experiences of the war — one man mute for two years after the Armistice, passing from one doctor to another, and finally sent to the Devonshire Clinic. The physician-in-charge, a man of experience, after a careful examination, realizes the ready possibility of a cure. It is lunch time; he turns to his assistant saying: "Start in on the case and we will complete it on our

return." But the man is already speaking before luncheon is over. He had been merely told to cough; it was explained to him that if he could cough, he could count, and so in rapid succession, sounds were produced till normal speech returned — a miracle if you will, but to the medical man, merely a psychotherapeutic procedure. Or consider again the young girl with insomnia of many months' duration, who, in spite of many medical consultations, had never a chance to unburden her mind of a secret worry of some years' standing; once the opportunity arrived and the explanation had been made, the insomnia was a thing of the past.

These everyday experiences, however, merely emphasize the need of more universal attention to the detail of human interest and understanding among the members of our profession.

And now what are we as doctors going to do about all this? What can we do in the care of our patients to give them those benefits which, to some extent, have been monopolized by the non-medical healers of ancient and modern times? What technique, if you will, is it our duty as doctors of science and friends of humanity to adopt?

I cannot lay too much emphasis on the importance of a careful and detailed *medical history* of our patient. Whether the disorder be of mind or of body, this method ranks easily first in the investigation. Without an accurate history, no diagnosis is possible, and diagnosis must be an essential precursor of rational therapy. Not

only does the history help to build up a logical substructure for your diagnosis of the disease, be it organic or functional, but it affords opportunity to establish early those relations of intimacy and of friendship which render the control and cure of your patient so much more easy. This history should include a sympathetic interest in his disappointments, his triumphs, his ambitions, his sorrows and failures — in other words, his personality problems. And these facts are not to be elicited by direct enquiry, by blunt analysis, but are merely incidentally culled in the patient's own words, and through a tactful and patient interest in his story. "I wanted," says one patient, "to talk frankly about my illness, and this alone has cured me quickly by restoring my self-confidence." Many a physician has acquired a reputation for professional skill through just such successes as these — a credit for divination because of a normal ability to elicit from patients the secret sorrows or repressed desires whose recital gave untold relief. It was Dubois, the medical moralizer, the opponent of drugs and operations, and the protagonist of pure psychotherapy, who was in the habit of using such phrases as this: "I cured him in three conversations"; for this was his chief therapeutic technique. The procedure is relatively easy, and is notably suitable for those simpler forms of neurosis in which emotional reactions produced by anxieties and conflicts have been misinterpreted by the patient and regarded as signs of physical disease.

This so-called therapy by moralization is the very essence of medicine of the mind, just as the theriac of the ancients was the essence of drug treatment, a panacea for all diseases. The medical case report, then, may afford, as I have said, the best opportunity for initiating relief or cure. I say "relief," or "cure," for the victim of organic disease shares equally with the pure neurasthenic the benefits; to each in his own way come comfort, hope, courage, contentment, or cure.

How all too common the neurasthenic travelling from doctor to doctor, from one clinic to another, enduring early mental conflicts without ever an opportunity to tell his story to a patient, tactful, and resourceful physician; not telling it in his own way, not being given the leads which make it easy, not having his inhibitions and repressions overcome by someone who knows how to prepare the soil!

Just think for a moment of the patients visiting your waiting-room for the first time, each with his own anxiety, eager to tell what you will let him of his morbid sensations, and each longing for the word or look that comforts or relieves!

Do you realize that there are as many hospital beds for mental patients in America as there are for all other diseases combined? that these too are filled, with patients in whom often a carefully considered medical history, with its psychological aspects and treatments, early in the course of the disease, might readily have prevented the further development of a

serious mental breakdown? Surely a medical history in these patients is no less important than in the case of appendicitis, tuberculosis, or cardiac disease! Dr. David Slight, the Director of Psychiatry at McGill University, realizing the advantage of such instruction, teaches his subject, for the most part, in the wards of our general hospitals, selecting the early emotional, behaviouristic or other functional derangements as a text. These are what our students should know and recognize, rather than study only the fully developed cases already confined in custodial institutions.

The Medical Examination. — Next in importance in the technique of psychotherapy is a careful medical examination, of double significance in helping to furnish a diagnosis and indicate the lines of treatment. From the point of view of psychotherapy, such a technique should be thorough; the average patient of today is not content with superficiality. There is so much publicity in matters medical, that if your work has the character of mediocrity, he is likely to know it. By thoroughness in your examination, you establish confidence, satisfaction, and courage, all of which are important factors in the alleviation or the cure. It is poor psychotherapy to forget any of the essentials in a medical examination.

Now psychotherapy, while it may seem to imply a knowledge of psychology, is, after all, to a large extent, nothing more nor less than the application of common sense to an understanding of human nature. I take it

for granted that your doctor will have the instincts of a gentleman — that he will have an imagination and a sense of humour without frivolity — that he will have an optimistic nature breathing the spirit of health and happiness and cheer wherever he goes. No object is gained by gloomy prognostications. People do not want a grave prognosis, and will preferably consult a second physician rather than accept your verdict. Nor would I recommend to the chronic invalid suffering from some incurable malady, treatments that worry and are irksome while they do not cure. Do not try too much the patience of your invalids with a daily routine which fatigues and wearies rather than helps.

Do not make miserable your advanced cardio-renal by too strict a diet, or imagine you can gain much in limiting too conscientiously in any way foods or pleasures which cannot reasonably harm. Cheer the heart with new hope, and you often establish or accelerate a cure. There is no longer any doubt as to the part played by mentality on physiological processes. Professor Cannon's epoch-making experiments have settled these conclusions for all time, and we know beyond doubt the influence of the emotions on pathological processes.

Fix in the mind of a gastric neurotic that his stomach is diseased, by ordering a special diet, and you make him a chronic invalid. Leave the impression in the mind of an acute emotional goitre that an operation is unlikely, and the symptoms readily abate. So control the attention of anyone with some chronic organic disease

that his mind is diverted from his symptoms, and he will improve, often believing himself cured even while the disease is progressing!

Physicians who concentrate too much on the symptoms of their patients send them away with added apprehension, with continued invalidism and physical and mental ineffectiveness.

In this way, some of the large practices are unconsciously acquired. Emphasize to the patient her floating kidney, her gastric ptosis, or her palpitation, and you have her on your hands for an interminable period, when a cheerful word or an expressed indifference to the importance of these conditions would make her a happy woman and relieve you of the burden of her care.

On the other hand, let me warn you against the error of being too casual in the directions you give your patients, lest in their failure to gain relief they go elsewhere for a cure. To the sufferer from obesity, do not satisfy yourself with a diet card, even if it seems specific in its directions. Here you must use every means of suggestion, explanation, and persuasion, lest in his inattention to your casual advice he gain his normal powers of resistance to temptation from some "divine healer" and give him credit for a cure!

A very important adjunct to psychotherapy, and indeed a very real part of it, are the small attentions for which you receive the gratitude of your patients and inspire them with added confidence and affection.

Among these are such commonplace enquiries as to the comfort of the bed and its appointments, the lighting of the room, the quality of the print she is reading, the preparation of the foods, the efficiency of the nurse in attendance — any one of the hundred trifles which are so important to the patient and should not be a matter of indifference to the physician.

How often does one prescribe some medication without even a word as to the method of using it or the purpose for which it is being administered! Medicine given with all the ceremonial which attaches to a useful therapeutics does not lose effect through being dignified by some words of explanation as to its purpose.

A good memory too is an invaluable asset to a physician; and if in your visits you can recall even the smallest item which lends to your patient an added conviction of your interest, it is well for you and her. This is not a pose, nor need it savor of the histrionic art; it is honest effort and good technique, and has its psychotherapeutic effect.

These are among the things we could learn, if need be. from the cults whose attention is riveted only upon the human interests and personal problems with which the patient has to contend. It is the germ of their major success, and that, too, despite errors of diagnosis and lack of scientific approach.

I should like before closing to say a few words on what is technically called "Formal Psychotherapy." As a craft or a specialty, I would earnestly deprecate it. Its very formality is its own undoing.

The psychotherapy for physicians needs no formula. It is, or should be, a part of his intellectual and mental equipment, just as is a knowledge of surgical technique. It should be an intimate part of himself, of his daily routine, of his so-called bedside manner, of his power to observe and understand. It is nothing new or difficult, nothing but what belongs to the heart and soul of every earnest practitioner, who has discretion, tact and some intuition. The psychotherapist who claims only one method of successful treatment for every kind of mental illness is as ridiculous as the osteopath who presumes to cure all manner of disease by manipulation of the spine, or the physician who prescribes digitalis indiscriminately in all affections of the heart.

The old-fashioned doctors, the general practitioners who stood *in loco parentis* as counsellors and friends, are fewer with the years, and personal contacts, except in the rural districts, are becoming less and less common. The rise of specialism is doubtless responsible to a large extent for the change, for the conscientious general practitioner, in the presence of highly-trained experts, yields the control of body and mind. This it is which, in the larger communities, makes the problem of psychotherapy somewhat more complex, for personal contacts are less frequent and less enduring.

As a medical man I will not presume to define or classify the various forms and methods of psychotherapy, all the more so as it appears difficult enough for the pure psychologists themselves to delimit the

borders of either. I will merely assume that any means by which the mental attitude can be improved is the objective. For this purpose, various techniques are called into service, all of them, including in its broadest sense the power of suggestion, whether in the form of hypnosis in the sleeping state or by education, persuasion, explanation, or analysis in the waking state.

I confess to a complete ignorance as to the proper category to which these should be assigned. To the patient the need exists for one or another or all. In the application of suggestive therapeutics, I would emphasize the imperative need of honesty, intellectual honesty, the avoidance of any technique that deceives; and so we deprecate the use of bread pills, electric belts and rings, or other amulets and charms, whose fundamental purpose is deception. We must not ask the patient with his eyes shut to swallow whole what we offer. If we use suggestion, let it be honest, encouraging, and soothing where we can, offering such drugs as may in their small way be helpful — hydrotherapeutic and electric treatments only as they may contribute to comfort, hope, or cure.

To mention electricity as a psychotherapeutic agent is a danger of which I am only too conscious, for in modern times few methods have been so abused and so feeble in their results. Someone has estimated that if all the electrical currents wasted on the limbs of hemiplegics could be stored in accumulators, there would be sufficient to supply a state with all its needs.

I recall in this connection, however, a patient with anorexia nervosa, to whom the severe application of faradism to the abdominal muscles gave a sense of stimulation — sometimes excessive. There was no thought of direct action on the gastric musculature, but merely of the general results from passive muscular exercise and stimulation. Improvement came rapidly, and within a few weeks, the patient became robust and well. This, again, is only suggestive treatment, but honest in its technique, for there was a definite purpose. Nevertheless I will not deny that the border line between quackery and honest practice is at times difficult to define, but there is at least one distinguishing feature — a careful diagnosis and a justifiable therapy to meet the case. Sometimes, as in the case of Dr. Coué, suggestion is aided, not alone by persuasion and education, but by concentration on the hope of cure, with meditation and a reiteration of the hope.

But I have wearied you long enough with a recitation of some of the ways and means by which a patient may get added care, human care, as well as that scientific advice for which you are all being so exceptionally trained.

"A physician may possess the science of Harvey and the art of Sydenham," says Osler, "and yet there may be lacking in him those finer qualities of heart and head which count for so much in life."

"It is for want of these," said the older Rolleston, "that great men are not always wise."

There is some truth in the epigram — "One-quarter savoir, and three-quarters savoir faire makes a successful practitioner."

Remember only this — that the basis of Medicine is sympathy and the desire to serve — and whatever is done to that end must be called Medicine.

III

The Medical Education of Jones

By Smith

WITH AN INTRODUCTION

By W. S. Thayer, M.D.

NOT long before the delivery of this address one of my old friends handed me a few typewritten sheets, asking me if, at my leisure, I would look them over. The manuscript was in the form of a narrative entitled: "The Medical Education of Jones. By Smith." This consisted in the main of reminiscences of one whose identity few physicians could fail to guess. With some of the incidents I was, indeed, familiar. My first thought, not unnaturally, was that my friend who calls himself by the somewhat equivocal name of "Smith," was writing autobiographically, but I could not identify Jones. When I saw the author a few days later, he emphatically denied that the story of Jones was in any sense his own history, and added that, while all incidents relating to Fowler were historically true, the other characters were purely imaginary. He had written for his own amusement and had shown it to me only because he knew how well I had known Fowler. He had had no thought of publishing that which he called his "squib."

As I read the narrative I realized that, imaginary though many of the characters might be, yet in its essentials the picture which was drawn was true; true in that it told true stories of a remarkable man; true in that it set forth the influence of this man, not only on Jones, whoever he may be, but on many men; true in that it drew a vivid picture of the human influence which the physician may exercise on patient, student, and associate.

It occurred to me immediately that the story of Jones, although not strictly related to "The Care of the Patient," might yet convey a moral to students of medicine. Accordingly I urged my friend to allow me to present it on this occasion. At first he refused, but finally he relented and consented, on the express promise that his identity should not be revealed.

On the whole, as I re-read the story, I think we must accept Smith's assurance that Jones is in great part, if not wholly, an imaginary character. Of one thing, however, I am sure: Jones is not Smith.

W. S. THAYER

1208 Eutaw Place, Baltimore
February 10, 1928

ONCE upon a time a young man — let us call him Jones — entered a school of medicine. He was a good enough sort of fellow, to whom medicine appealed from both its scientific and its human relations. He was by nature what one might call a strict constructionist.

He had an inquisitive mind. He wanted to know the reason why; and he was not satisfied if he could not find out the reason why. In school he had been a good mathematician, and he was used to the exact methods of mathematics. He had lived in close association with lawyers. He was familiar with the analytical attitude of the legal mind. His cousin, a little older than he, with whom he had grown up as a brother, was a lawyer, enthusiastically interested in his profession, and the medical student was fascinated with the accounts of some of the cases which were related to him. The human side of these stories appealed to him as well as the precise, inviolable rules of evidence from which deductions were made: those rules which excluded hearsay, opinion, or conviction; which demanded the rejection of all excepting that to which the individual witness could testify. These exact rules of procedure appealed to his reason.

He had been brought up to love and trust his family doctor. Somehow or other he had come to regard his family doctor as more or less infallible. Unconsciously he had assumed that in medicine there were precise rules of procedure, of diagnosis, of treatment, similar to those in legal procedure. He had supposed that, if in medicine like careful, exact methods were followed, the way was clear. In a vague manner he had come to feel that a departure from the rules of medicine was as unpardonable as a departure from the rules of legal procedure; that misinterpretations were inexcusable.

His father, an able practitioner of law, had died some years before he had entered the school. His mother and his family, of a rather high-strung, nervous type, were in general cultivated people and well read. Despite this, their conversation was very largely about individuals. At the dinner table and about the open fire in the evenings, he was accustomed to hear and to take part in frequently recurring critical discussions and speculations as to the motives and acts of this, that, or the other man or woman, friend, acquaintance, or public figure. In general the family, though not intentionally unkind, were very free in expressing their opinions and their criticisms of the motives or behaviour of others. His father had been different. Naturally a student and a scholar with a delightful humor and an unusual sense of the value of words, his conversation had had a peculiar charm. In his day individuals had been little discussed. But that was long ago. Little by little Jones had begun, rather sadly, to feel that, at least in public life, men were rarely sincere. He was often puzzled by the peculiarity and inexplicability of the actions of men, all the more because when, now and then, he was thrown into association with some of these people whose peculiarities he had heard discussed, they seemed to be rather decent fellows. But at home it was about individuals, their faults, their peculiarities, that the conversation turned.

In college and in the school of medicine his early studies of the fundamental sciences he had found most

interesting. Even there, however, when he came to the study of pathological anatomy and such questions as the classification of tumors, he was a little annoyed by the lack of exact and definite distinctions. When again he began to approach the questions of physical diagnosis, he was rather surprised by the difficulty of reaching conclusions; by the absence of rules by which to proceed and interpret; by the realization that so much depended on individual skill. And uneasily he began to appreciate that his family physician could hardly have been so infallible as he had fancied.

When he approached the applications of pharmacology, he was truly disconcerted by the lack of exact methods in practical therapeutics. He had approached medicine as a science, as he might have continued his studies of mathematics, and it had annoyed him and worried him to hear others say that medicine was not an "exact science." He had resented the use of the term, "The Medical Art." To speak of medicine as an "art" seemed to him to be a disparaging reflection on the profession that he had chosen; and now here were his instructors pursuing methods which were anything but exact.

He was a rather sensitive fellow, and among his teachers were men who seemed to him shallow, who did not measure up to the standards of his ideals. This hurt him.

He did well. He obtained a good interneship. He sought, so far as he could, to employ in his work the

more accurate methods which he had learned in his earlier training, toward which he turned by nature. He had a good service in a well-conditioned hospital under two chiefs, both good men, who, outside of their practice, gave considerable time to the study of their material and to teaching. The hospital was an active institution, connected with a university, and teaching was carried on in wards and in the small clinical laboratory. During his interneship he was himself in frequent association with students; this was good for him.

There were few visitors. A visiting physician who came to that hospital had a rather hard time. Unless he had a letter of introduction, he was not welcome. One of the annoyances to which Jones was subjected was the visits of occasional outsiders who interrupted him in his busy day. His chiefs were busy too, and the unintroduced visitor was soon made to feel that he was in the way and unwelcome.

More and more during his hospital service Jones was impressed with the smallness of the group of men in this country who really knew anything about medicine, and he began to feel that, except by a few men of the immediate circles surrounding the better schools and hospitals, the practice of medicine in America was deplorably bad. The stories that his patients told him of the opinions and the diagnoses of their physicians outside surprised and distressed him.

The commercial attitude of some of his instructors shocked him. There was Dr. C., whose charges were

from all appearances based entirely on the supposed financial condition of his patients. Had not his friend Greene told him how he had warned Dr. C. that a certain patient was well-to-do, which C. had not appreciated; and then, after C. had arranged all the conditions of the operation, had he not gone back to the patient and told him that, on reconsideration, the responsibilities associated with the operation were so great that he should have to change his charges — C., who was regarded in the community as a saint!

From other friends he had heard of their discouraging experiences on entering practice. Everybody was for himself; you could never leave your patients for a needed vacation. You would lose your practice, not to speak of your reputation.

While he was a good deal impressed by the inexactness of medicine and the difficulty in reaching that certainty which had seemed to him so necessary in any serious procedure, here were these "outside" men with indifferent training, enouncing positive opinions, nay, assertions, as to all manner of things. This disturbed him; they could not be honest. "Honest!" said some of his friends in practice — "Honest! You never saw such a set of sharks as the men you meet with 'outside.' Ideals? There are none. Don't you ever leave this town. You've no idea how different the spirit is everywhere else."

After his interneship, interested but in some ways rather discouraged, he spent a year in the laboratory of

Dr. Y., in order that he might strengthen his foundations in one of the branches of natural science which was beginning to be called upon more and more in the effort to discover the nature of a variety of manifestations of disease. Here was a man working on fundamental problems. And what a fascinating man he was! Master of his own time, removed from the cares of the world and from those distracting human relations which take from the practitioner most possibilities of continued thought or study, his active mind was given wholly to the investigation of special problems by methods of scientific accuracy, and to broad and interesting speculation as to the relations of these problems to life and the universe. The year passed too fast. Of medicine he saw little or nothing. But as the months went by, more and more the thought of the pettiness, the indefiniteness, the unsoundness of the general practice of medicine weighed upon him. How could one practise medicine conscientiously without applying throughout the accurate scientific methods of the laboratory? How could one honestly treat his fellow when obliged to grope in the dark as most men seemed to be groping? And what could one do in practice if one had to treat with such men as the majority of doctors seemed to be? True it was that, save for occasional visitors and his instructors, he had met few practitioners of medicine. But he had gone one day with a friend to the meeting of one of the recognized medical societies of the city, and there he had heard a discussion on "dropsy." Men who were caring

for human beings had talked in a way that made him shiver. Had he not heard one man describe the transformation of a case of "dropsy of the chest" to a "dropsy of the abdomen" on change of position during which the speaker had heard the fluid "trickling through the diaphragm and dropping into the belly"?

He had heard some learned discussions at one special society. With regard to other associations of physicians he had heard little that was good. The American Medical Association? That, he was told, was run by a "Chicago ring." On one occasion he had met one of the officials of the Association. This man seemed to him "Western." He had never been in the West, but he fancied that these good fellows who had not had all the advantages that had come to him, had an annoying tendency to generalize and act hastily. And then — they did not have the same ideals.

But he had to make his living. Happily, at this moment, an opportunity was unexpectedly opened to him to spend a year of post-graduate study at the Skipwith Hospital in Cecil in the Clinic of Dr. Fowler, who had, for some years, directed the medical service. This chance he gladly accepted, but he left the laboratory regretfully, depressed and despondent. It would have been a joy to him to be able to give his life to studies such as those in which he had been engaged; but that was out of the question.

At Cecil, Fowler soon found a position for him in his service — one which not only afforded him an oppor-

tunity to make daily visits in the general wards, but gave him some responsibilities with private patients and made him a member of the hospital family. It was, as it were, a second interneship.

It was not long before Jones fell under the spell of Fowler whose personal brilliancy and charm were irresistible. What struck him first was Fowler's simplicity. From the beginning to the end of his daily work, with patients, with students, in laboratory, in lecture room, in public, wherever he was, he was always the same figure. Never a pompous word or gesture or attitude; never an attempt to be flowery in speech. Everywhere he was his simple, natural self. Occupied without interruption from morning till night, he never seemed to hurry, but he wasted not a minute of time. With a swinging step, thoughtfully stroking his long dark moustache, he moved from ward to ward surrounded by house officers and visitors. There was a word for all, but with never an interruption of his routine. He did not seem to hurry, but one could not stop him or hold him. He was everybody's friend, and the kindly, frank glow of those deep brown eyes with the oft-recurring lightning-like twinkle of humor was indescribably winning. On entering the ward, a greeting to the nurse, tinged perhaps with humorous raillery which left a blush, half of embarrassment, half of pleasure; a quaint remark or a cheerful word at each bed; some clever but never unkind, epigrammatic comment on the patient's appearance or history which caused an explo-

sion of laughter in which all joined. In the private rooms, it was a continuous sequence of gay jest, droll and insistent discussion, discriminating silence, quiet cheer; the patient, generally stimulated to laughter or a mixture of perplexed vexation and amusement, in which the latter always predominated, taking him out of himself and the troubles of the moment. He never left a room without leaving behind him renewed hope. There was that in his eyes which commanded affection. He said little. He never moralized or preached. But many a poor wretch felt the momentary touch of his hand and looked into those eyes, and was at peace.

He had a rare power of gaining the confidence and eliciting the confidences of his patients. And when the nervous invalid had once spoken, he had a consummate skill in preventing that repetition of complaints through which, so often, new fuel is added to the fire. At the outset he gave the sufferer one or more long and patient interviews. Thereafter the fashion in which he frustrated all attempts at repetition was masterly. Day after day the patient would hoard his doubts and his questions. The list, carefully prepared, would be held ready for the next visit. The day of the visit came. The door opened. Fowler entered with a smile and some little, quiet comment so clever, so disconcerting, so funny, so amusingly scandalous perhaps, that in a minute a lively or earnest conversation was under way; and then, usually in a burst of gaiety, he was gone. In the evening when the assistant made his rounds, the

patient, with a wrinkled forehead, would complain that he had forgotten to ask Dr. Fowler those questions that were so important. And so it would go on day after day, week after week, until those vital questions had vanished from the consciousness of the refreshed and regenerated convalescent.

He was imperturbable. His self-control was perfect. His gaiety was irrepressible. Excepting when actually at his work, he was rarely serious. He saw the humorous side of everything, and his day's journey sparkled with airy comment made with a peculiar unexpectedness and drollery which were all his own. One day one of his assistants brought him a stupid little boy from the out-patient department who had a dimpling in his neck, clearly the remains of gill-clefts. Fowler was just leaving the ward. He put his hand on the boy's head and said: "Ah, yes! ah, yes! How batrachian! I — I say, my boy, do you ever feel as if you wanted to take a swim?"

Again, in consultation with Dr. R., he saw an entertaining and amusing old alcoholic wreck. After the consultation there were a few minutes of gay bantering, and as he was leaving the room, in the midst of general laughter, the patient cried out: "Hold on, hold on, Dr. Fowler! You have n't told me a word about myself or what I should do!" Fowler tiptoed across the room, picked up the lapel of the patient's coat between two fingers, pointed to the button-hole, and, in a stage whisper, "Put a little blue ribbon in there." That was all.

In the private ward was a young girl with a singularly dull, expressionless, moon-like, bovine countenance. Fowler, forthwith, christened her the "Manatee or sea cow," an appellation which filled him with joy. He never knew her other than as the "Manatee," and in after years at unexpected moments, with a chuckle, he would turn to his old assistant with the exclamation: "Do you remember the 'Manatee'?"

Wherever he was, the most unexpected and often mysterious little practical jokes were played upon his friends.

Once in his early years at Skipwith, before his name had become well known, Fowler was asked by a colleague to look over one of his patients before operation. The patient was a rather amusing, bright, somewhat airy woman. As Fowler entered with his assistant Tanner, he was greeted by a cordial: "Is this Dr. Fowler?" "No," said Fowler, "this is Dr. Tanner. This," pointing to the assistant, "is Dr. Fowler." The patient recognized immediately that "Tanner" was the Chief, and at the end of the examination, looking up rather gaily, said: "Now, Dr. Tanner, what is the matter with me?" With a sweep of the arms Fowler replied, "Madam, I have not the least idea in the world!" The patient, laughing, exclaimed: "What, the great Dr. Tanner does n't know what is the matter with me?" Whereupon everybody burst into a gale of laughter, and with a few gay words Fowler and his cortège left the room. It was several days before the patient dis-

covered that "Tanner" was Fowler. Such things were constantly happening.

Jones and Tanner lived next door to Fowler. One day Tanner was on his way to Tremont. As he came downstairs he was surprised to find by the front door several packages addressed to Jones and to him. He investigated; there were two cases of claret and several boxes of good cigars and cigarettes; but there was no card, no letter. They appeared to have come from the Cecil Club. He was mystified, but on the train he suddenly remembered a conversation of several hours before. As he was leaving his chief's house, Fowler had said to him, "By the way, Tanner, I saw an old friend of yours at the Cecil Club to-day. I can't remember his name. An old physician from Tremont — a dear old friend of yours with a long, white beard." Tanner was at a loss. He could remember no such man. "Oh," said Fowler with gentle impatience, "of course you remember him. He spoke of you with particular warmth, and asked me not to forget to give you his love." From Tremont Tanner wrote a line to Fowler to express the hope that the shadow of the white beard would never grow less.

On one occasion at a dinner, each guest found by his plate the sample copy of a new magazine, the realization of a project which had been discussed for sometime. In the table of contents were the titles of a series of communications by authors, for the most part present — but the titles, wittily conceived, were utterly ridiculous and cleverly adapted to set forth the characteris-

tics and foibles of the author. The rest of the volume was blank. On another occasion, in the midst of the long programme of an important meeting appeared the title of a paper, to say the least surprising, under the name of a colleague whose enthusiasm was by some supposed to lead him at times to the publication of records of researches bordering upon romance.

Complications, seemingly insurmountable to others, were dismissed with a wave of the hand, a laugh, and a word — a Parthian arrow, which usually turned the apparent surrender into an ultimate victory. He never entered a disagreeable controversy unless it was necessary. No one knew so well as he when it was actually necessary. This continual gaiety, not to say levity, was at times trying to serious associates who were endeavoring to pin him down. Fowler seemed sometimes to dodge the issue or to give way unnecessarily in order to escape an unpleasant moment. But he knew best, and in the end he generally had his way. His gaiety was a coat of armor which shed bores as a coat of mail shed arrows.

Once when a really serious controversy with a committee of ladies seemed imminent, he gave in — "as usual," said his impatient assistants — but with a laugh and a sly remark which took root in the minds of his opponents. In due time they came back to him with his own proposition. During the discussion, after an annoying interview, he said to his assistant: "Tanner, Sister Maude is more sensitive than sensible. The only

way to get along with a woman is never to treat her seriously." And he never did — outwardly.

But when it really was necessary to take an unpleasant stand, he could do it with a vigor which was surprising to those who were familiar with his usual gentleness.

Rarely, very rarely, did his indignation get the better of him, but one day, in a private room, a peculiarly silly woman began to talk to him about the beauty of his eyes. Suddenly the eyes flashed — "Woman, don't you dare to talk to me like that!" — and he left the room.

Fowler always saw to it that his assistants, apart from their routine work, should interest themselves in some special subject in laboratory or ward. The results of their work were sometimes used in his own publications, sometimes published as special articles by the man himself. But wherever or however the results of these researches or analyses appeared, the author was always given full credit. Fowler never failed to mention the name of the younger man whose labors had contributed in the simplest way toward the accumulation of material for any of his publications. His assistants appreciated his thoughtfulness and loved him for it, for they well knew how common it was in other clinics for the Professor to make use of the work of his assistants with little or no recognition.

Before many months had gone by Fowler asked Jones to present an unusual case before the medical society and later to record the observation in a short note in the "Gazette." He went over the material when it was

ready and gave wise advice, particularly as to the elimination of several unnecessary passages. As Jones left the cozy study from the walls of which Linacre, Harvey and Sydenham and Cardinal Newman looked down upon him, Fowler called out: "Oh, by the way, Jones, don't forget to put in a word of recognition of the nurse."

In his great work that went through so many editions, he never failed to mention, wherever possible, even the most modest of his assistants; and to this day, after nearly forty years, the name of the nurse who copied for him the temperature curve illustrative of typhoid fever, is recorded on the chart.

In his simplicity and directness he was sometimes dramatic. Wordley, the distinguished oculist, when a young man, had a consulting room at Westerly where he spent a day each week. Once at luncheon a local physician said to him: "Fowler is coming down to-day to see Mr. V. Should you like to come with us?" Wordley, naturally, was delighted. Together they met Fowler at the station and accompanied him to the house.

V. was a leading citizen, a pillar of society, foremost in good works, an ardent prohibitionist. He was very ill, comatose.

At the end of the examination, sitting by the bedside, Fowler tapped the patient lightly over his liver, shook his head, and, looking up at the brother and the doctor, said simply: "Too much alcohol!"

"Oh, Dr. Fowler," replied the brother, "you've made a serious mistake there! I doubt if my brother ever took a drink in his life."

"Sure?" replied Fowler.

"Why, I'm as sure as I am of anything."

"Where's his office?"

"We've offices in the same room. Day in and day out we've been together for years."

"Where is his office?"

"Close by."

"Let's go and see his office."

They went to the office.

"Have you the keys to this?" said Fowler, pointing to V.'s large desk.

"I'll get them."

They opened it. Nearly every drawer and compartment contained empty or full bottles of whiskey.

V. had suffered from insomnia, and nightly for years he had risen from bed and gone "to work" in his office where he had drunk from a pint to a quart of whiskey. He had warned his wife not to mention his troubles and habits to others. They "might suspect him of something." She, loyal soul, had never suspected.

His valued friend Forest once called him in consultation to see Mrs. Q., a lovely woman with grave cerebral symptoms the nature of which was but too clear. Q. was a dissipated fellow. They left the room. Fowler put his coat on and started to open the door when Forest put his hand on his arm saying: "Wait a minute,

Dr. Fowler, you have said nothing. Let us have a word together." Fowler shrugged his shoulders: "What is there to say?" "Well," said Forest, "What shall we do?" Fowler took several quick steps across the reception room toward the clock on the mantelpiece. With a gesture as if turning the hands backward, he said: "Five . . . ten . . . fifteen years — and strangle the husband!"

Those medical agents the action of which was well known were used when necessary, and judiciously; but in Fowler's wards there was little experimentation with new and untried products, and in the main it was upon the simpler physical and mental agents that he depended. Rest, massage, fresh air, a proper diet, good nursing, and, above all, the amazing mental stimulation that this man brought. Early in his association with Fowler, Jones was struck by the discriminating art with which this powerful therapeutic arm was employed.

Fowler was human and had his difficulties in diagnosis, which he often expressed, although his clear vision and rapid, lucid reasoning led him generally to the kernel of the situation with remarkable speed and sureness. Somehow, with this simple man, who was never pompous, who made no pretence to superior knowledge, who was always ready to confess his ignorance or his doubt, who swung in and out of the hospital with a song — in the presence of this unpretentious, informal man who treated him as a companion rather than as a student or assistant, Jones lost for the first

time that lurking disappointment in the inexactness and incompleteness of medicine which had so discouraged him. This man in a way inspired the feeling that he had had for his old family physician. He knew Fowler was not infallible, but the sting of fallibility was gone; he no longer felt it. More than that, he would not have had him infallible; had he been infallible, he would not have been Fowler.

And then there was another new and interesting experience which came to Jones at Cecil. In the hospital of his first interneship the visitor had been rare and unwelcome, and the post-graduate student unknown. Here Fowler was always followed by a group of post-graduate students and visitors, for the most part country doctors, and he seemed to enjoy it. Sometimes these men were rather crude and rural, not to say rustic, in their appearance, but Fowler treated them with cordial informality almost as intimates. Frequently one was carried to luncheon or dinner. Almost daily one or more came to his house for tea, and when Fowler spoke of them it was always with regard or appreciation, sometimes warm. Jones was astonished to find so many of these visitors remarkably agreeable and intelligent men.

Fowler's wife was his perfect complement. Handsome, strong, vigorous, bright, understanding, she was an ideal companion and the friend of his friends. She filled every gap in his life. And when, in the midst of a busy day, he appeared with some new and often

strange figure for luncheon, it was she who entertained the guest when her husband plunged into the activities of his busy day.

Once, with laughter and mock despair, she said to Tanner: "I've had a dreadful day! Dr. Fowler brought in a nice, old, white-haired, country doctor for luncheon. He was nearly stone-deaf. Every time he turned his head to speak to me, Dr. Fowler whistled or sang or drummed on the table or told the most dreadful stories you can imagine. Fancy my position! And then, after about twenty minutes, he ran away and left the old doctor with me!"

One day Jones started to comment in a light vein on something which a rather amusing figure, an old physician from a distant point, had said or done. Fowler changed the subject abruptly. Once again, when he said something about the commercial attitude of Dr. C., Fowler again changed the subject. One Saturday evening, when a group of students were gathered about his dining-table, an old classmate who happened to be in town said: "Oh, Fowler, do you remember — ?" and so forth, speaking of some ridiculous act or error of a colleague. Before the words were out of his mouth, Fowler had turned and, pointing to the large photograph above the sideboard, said: "Do you not think that statue of King Arthur in the church at Innsbruck is remarkably fine?" The students shivered; the guest flushed and held his peace.

Fowler was a quickening spirit. Wherever he passed the world smiled. Listen to this incident told by one of his dear friends — a wonderful picture of him as he appeared just after his marriage.

"In the deepening twilight of a late autumn afternoon nothing could look harder nor more uncompromising than Jefferson Place. A poor woman, utterly worn, carrying an ill child, laboured up the square, and then suddenly sat down with a sigh on the stone coping bordering the grass slope. The child's heavy head turned restlessly about on the woman's bosom; her whole body sagged over the baby to keep him from falling. About them was the bodily fatigue and mental inertia of the hopelessly poor.

"The square was almost empty — a newsboy or two, a stray cat, and a young woman wondering what she should do.

"Suddenly the scene changed. From being hard and sordid, it became warm and human and radiant. Apparently the gayest of men came up the square, humming to himself, and adroitly twirling his cane. He wore a silk hat and a dress overcoat, his eye glanced here and there, amusedly at the ugly fountain, reverently at a little fleecy half moon, and then fell upon the woman and child. Instantly the twirling cane made a playful dive at the child. Then cane and gloves were tossed aside, and he tenderly took the child into his arms. A few words only to the woman, a gentle placing of the child back in her lap, a whistle to a newsboy, with

an injunction to get a cab 'quicker than he could,' — spurring him on with a wink of his eye and a jingle of coins in his pocket, — and in a perfectly incredibly short time he had the child and woman in the cab.

"'Now then,' he said to the driver, 'go to the Skipwith Hospital, front entrance. And here' — he dived in his pocket, found a card, wrote something on it, gave it to the woman, laughingly saying 'I have told them the boy is Mrs. Fowler's youngest. That will make them take care of him until I see him to-morrow. And here' — he took out a five-dollar note — 'take this, go home after you leave the boy, and make yourself just as drunk as you can with it.'

"He patted her on the knee, pinched the child's cheek, paid the driver, slammed the door, and went whistling on his way.

"The witness of this episode gasped. She caught her breath with the exhilaration that comes when rapid action gives the impression of immense leisure. To her, as to most people, life has brought many disasters; but when almost beaten to the ground, she remembers the woman and the child and the coming of a great physician, and listens for his step."[1]

He was everybody's friend. He never said an unkind word of another man, especially of a colleague, behind his back. And in his presence no unkind word could be spoken. Wherever he went, peace accompanied him. Sometimes it was almost annoying, the cordial way in

[1] Edith Gittings Reid.

which he greeted and joked with Hornblower, the medical romancer whose profound researches, composed at his desk, deceived many and so annoyed those who understood. But then, in Fowler's presence, Hornblower became inoffensive. Before Fowler his pompous manner and arrogant assertions disappeared. He was quiet and almost modest in his demeanor, and talked sometimes interestingly of things that he understood, for in some ways Hornblower was rather well read and not unintelligent.

The medical community of Cecil was not wholly harmonious. There were two schools of medicine: the old, with a distinguished past and a faculty which contained many worthy men; the new, with a large endowment, and great prestige, to which Fowler and other members of the faculty had been called from distant points. It was not an easy situation, but Fowler was everyone's friend. At meetings of state and city societies Fowler was always on hand. More than this, he was insistent that his associates and assistants should also attend and take their part in these meetings, and Jones began to form associations with a number of men of the other school as well as with practitioners who were its graduates. Before long he began to appreciate how large a body of good practitioners, of men with high ideals and sound common sense, there was in the community. Fowler was everybody's friend. Even Dr. H., the bitterest enemy of the new institution, who seemed to suspect everyone else of ulterior motives, was Fowler's

intimate. But in general the profession and the town in its allegiance remained divided — save in the presence of Fowler. Where Fowler moved there was peace.

What was the secret of it all? Little by little a simple but profound truth began to dawn on Jones's mind. So long as you have never uttered an evil word of another, so long you can meet him cordially and openly, with a clear eye; so long you can live with him and work with him in peace; so long you can profit by his experience or accomplishment or judgment; so long you can exercise on him such influence for good as you may be able to command. Let but your ear hear the word of your mouth which disparages your colleague and peace is gone. You can no longer meet him with the same clear eye; you cannot take his hand without remembering the words you have said behind his back; you are ill at ease; you are no longer his friend; free communion is impossible. The very sound of your own voice has opened the door to further suspicion and doubt, has estranged you and made you an enemy of one you would have helped. And then, was it for you to have passed judgment? Fowler never spoke an evil word of a colleague and could look every man clearly in the eye; and every man was better for his association with Fowler.

And then Jones began to realize how with close association in medical societies the differences between men of different schools disappeared. There were no differences. Why had they distrusted one another?

Purely from the lack of association. Isolation and separation had opened the door to all sorts of doubts and suspicions.

But the stories which his patients had told him of their doctors still disturbed him. What he had seen this year of country doctors was hardly in accordance with that which his patients and his friends had told him; and yet they were surprising and definite stories, those which his friends had told him. He had had, it is true, one very interesting experience. In connection with some studies that he had been carrying out, Fowler sent him for a day or two to that part of the country where the particular disease prevailed, a distant rural point, with a letter to the local doctor. He had expected to find rather a crude character; he had found a physician of good training and experience, a scholar among his books, and a gentleman and a high-minded man. But he still had a rather poor opinion of the country doctor as such.

In June, Fowler offered Jones the opportunity to stay for another year and sent him away for a month's vacation. One day, on a cushion of green moss under the spruces and firs and white birches of the northern woods, Jones, with rod and creel by his side, lay on his back looking upward at the blue sky. The little white flowers of the bunchberry and fresh leafy ferns bordered the gray rocks that lay along the banks of the mountain stream. It was still, save for the music of the hermit thrush and the clear notes of the white-throated sparrow as they echoed through the woods. Hospitals and wards

and medicine were far away; but now, as he lay gazing dreamily upwards through the leaves, his mind wandered back over the past months. A year before when he had left the laboratory he was wretched; now he was care-free and happy. What had happened? A year before he had been depressed by the thought of what was before him and full of doubt and unhappiness at the realization that medicine was not an exact science, the practice of which could be governed by mathematical rules; full of suspicion of the motives and the character of the average practitioner; full of longing to give his life to the pursuit of definite clean-cut scientific problems in the laboratory. And now he was at peace. Those annoying reflections which had circled around the words "science" and "art," which had so disturbed him then, how small, how almost comical they seemed now! And medicine, what a wonderful opportunity it offered! Based on the fundamental sciences for the aid of which it was reaching out more and more every day, what a fascinating problem the art of medicine! What curious misapprehensions had been his! How little had he grasped the significance of the human side of medicine! What a childish, ridiculous thought that medicine could be practised by rigid rules; that the day was near when we could seek the answer to every diagnostic problem by a chemical reaction; that we could treat our patients by rule of thumb! What an absurd fancy that all the physiological and chemical and physical knowledge in the world could give one the

art of Fowler without laborious study and practice at the bedside and in association with human beings. And what an immense reward to gain in the end — something of the deftness of touch, the keenness of vision, the sureness of judgment which only experience can give!

One thought sobered him. There was still such an immense need for more fundamental training, and more basic knowledge, and more men in medicine who had a scientific point of view. But the art — and he had resented the word! — how fascinating it was!

He still regretted the quiet life of the laboratory, the exact methods, and the special problems to which he might devote his whole time; but he had to earn his living, and now, with the new problem before him of the acquisition of the medical art, he was resigned if not contented.

The second year was a repetition of the first. Fowler's actions were a never-ending source of interest. He had insisted that Jones join the American Medical Association. His previous instructors had not been interested in the A.M.A., devoting themselves wholly to special associations. Fowler not only attended the meetings, but took Jones with him to a gathering in a large Western city. There he presented him to most of the men of distinction and took care especially that he should meet X., who had just entered upon important duties in the Association and was making efforts to regenerate it and build it up. That trip was a revelation to Jones. The directness and simplicity and enthusiasm

of many of the men that he met was an inspiration. One thing especially set him thinking. What had he meant when he had called a man "Western"? Somehow, the thought that they had not had the advantages that he had had. And yet among others he had met a man old enough to be his father, born in the West, the graduate of a Western university, not only an able physician, but a classical scholar with a beautiful library, a more cultivated man, by and large, than he was ever likely to be himself. It mortified him to think that, in his ignorance, he had been assuming a condescending air toward his superiors.

Those Western men and some of those very men whom he had heard talked of as the "Chicago Clique" had a vigor and strength, a freshness, a hopefulness and a cleanness that stimulated him greatly. There was something big and healthy and frank and moving about it all. This, after all, was America — and he was proud of his country.

He was impressed by the faces of the members of the Association — earnest, serious, fine-looking men for the most part. It was charming to see the way in which Fowler met and fraternized with all. Jones began to appreciate more than ever the significance of Fowler's insistence on the value of association with one's colleagues.

The year went by rapidly. Christmas Jones spent at home. It was good to see the family again, but he was annoyed by certain unpleasant tendencies that seemed

to have developed. His people appeared to talk only of individuals and their errors. He was besieged with questions as to the local physicians. Had he heard what Dr. X. had done? What could have induced him to do such an extraordinary thing? Dr. Y. had told them that it was an entirely indefensible proceeding; etc., etc. And when he smiled and replied: "Dear B., I am sure I have not the least idea. I only know that if X. did this, he had a good reason; and of one thing I am perfectly sure, that if X. did do this, his motives were honorable and high, for he is incapable of acting otherwise than honorably" — he was accused of trying to lecture his family in a superior moral tone.

But his cousin the lawyer said one thing that pleased him: "Harry, do you know I was much interested in the reprint you sent me. I did not know that medical men gave accurate references to the authorities on which they based their statements. That really has given me more respect for you physicians."

The vacation was short, but much as he loved his family, he was not sorry to leave. An atmosphere of discussion and criticism of others with which he was quite unfamiliar seemed to permeate the family circle. It pained him and made him uneasy.

At the end of his second year he left, to start in practice for himself in Warwick, a city of some 150,000 inhabitants. Here Dr. Thompson, through his acquaintance with S., one of Fowler's assistants, had offered him an opportunity to practise in connection

with his clinic. Warwick, like Cecil, was divided medically. There were two schools and a recognized leader of each school, and the rivalry ran almost to open hostilities. The leaders barely spoke to one another. There were constant rather angry controversies between the two groups and their patients. One of the Cecil graduates had gone to Warwick some years before, an able fellow, a man of apparent promise. He was probably the best-qualified man in his particular line in Warwick. But after a few years he had left, confessing to friends that the atmosphere of constant rivalry and jealousy was more than he could endure. In reality, he had had small success. He had made few friends. He had not profited by the example of Fowler. He had taken himself too seriously. He had somehow felt that a proper regard for his training and his powers had not been shown. His colleagues had not been slow to detect his high opinion of himself.

Before Jones left, he dined one evening with Smith, a plodding fellow, an assistant of Fowler. They talked of many things, but mainly of Fowler and what he had meant to them both. The older man said to him: "There is need in Warwick for just such a man as you. There is a good body of medical men at Warwick and, in general, they are unusually nice fellows. If you remember Fowler's example and, above all, if you can remember that they are decent fellows; if you can forget yourself and remember only your profession and your patients; if you can, as Fowler does, keep your mouth shut, take

an active part in the medical societies, remember how little you know and how much you have to learn; above all, if you keep an ice-bag on your head and don't take yourself too seriously, you'll make friends and succeed."

Within a month after Jones went to Warwick, he was invited to speak at a medical society which met in a country district. It was the first time he had ever met a large body of country practitioners. The meeting lasted three days. To Jones it was a revelation. He found himself among an earnest, eager, clear-eyed set of men. Many had had a rather slim early training, but as he talked with individuals, he was impressed by their common sense, their intelligence, their openness, their genuine devotion to their profession. And he came back with the conviction, which grew stronger with the years, that the average country doctor was a far better man than the average city doctor. "Of course," he said to himself, "he should be. Some men in the city have unusual advantages. Others perhaps excel in special lines. But can anything more fully develop the strength and character and sound judgment of a man than the responsibilities which the conscientious country doctor must bear? In the city help is always near; in the country men must help themselves."

The experience which impressed him most was a talk with Dr. H., a manly, clean-looking fellow who sought him and asked if he remembered Mrs. R., whom he had sent to the Skipwith Hospital two years before. Now Mrs. R. he remembered very well. The case had seemed

to him a most serious example of neglect by a country doctor who must have been a deplorably ignorant or conscienceless man. The patient had not blamed her doctor, but had told the story of her illness, of what she had been told, and what had been done. The two men sat down and talked it over. When they parted, Jones realized that this man who, for two years, had been to him a painful example of what was worst in medicine, was an unusually fine fellow, who had treated his patient with intelligence; who had sent her to the hospital for good reasons, wisely, and at the right time; who had thoroughly appreciated the situation, and had been directly responsible for the happy result which had followed. How had he so misjudged this man? It was simple enough; he had never appreciated how impossible it often is to get at the truth of any story that passes through a third person. How many other men had he misjudged in like manner? What a confirmation of Fowler's wisdom! How vitally important it is to play the game together; to know your colleague and work with him.

Jones succeeded; he held his tongue, he remembered and sought, as best he could, to follow the example of Fowler. He made few enemies and many friends. In the midst of discord he lived in peace. He observed the improvement of conditions in his own city; he saw the American Medical Association grow and exercise its influence for good in bringing together and unifying the

profession. Surprising changes had occurred in his own community. Through the local branches of the American Medical Association and many special societies which had arisen, medical men in Warwick as elsewhere had been drawn together more closely. Improvements in methods of transportation had brought the city and country nearer together, and the relations between physicians in city and state were far more cordial than they used to be — simply because the doctors knew one another.

As he came to know men as the conscientious practitioner must know men, the misanthropic doubts of his earlier years began to clear away. As time went on, it was not the selfishness and pettiness and ingratitude of the world that impressed him. It was rather the kernel of sincerity and idealism and beauty that lay hidden in the majority of human beings, curiously concealed, often, by the forbidding armor of atavistic fear or suspicion or by the scowl of naïve self-consciousness, but ready in the emergency to manifest itself in acts of love and self-abnegation and heroism. The world was a better world than he had fancied.

Twenty-five years passed by. Great changes had taken place in medicine. Through the introduction of procedures diagnostic and therapeutic, based on the application of the fundamental sciences, in particular chemistry and physics, the importance of which Jones had wisely foreseen as a student, remarkable advances

had been made in the science and art of medicine. Clinical departments in many schools were beginning to be respectably endowed. The opportunities for post-graduate study were as good at home as abroad. Clinical services which, in his day, had had but a single laboratory equipped only for routine work, now had their own divisions especially equipped for physiological, biological, chemical research. An attempt was being made in the better medical clinics, not only to deliver the director, by a more or less adequate salary, from that financial anxiety which so interferes with the work of the teacher and the investigator, but also to offer to younger men those opportunities for which he had so longed — opportunities to acquire experience and pursue research in the bosom of the clinic as salaried assistants and associates.

Researches in no way inferior to those carried on in the laboratories of the fundamental sciences were being pursued by members of the clinical staff.

One thing he regretted to observe — the apparent lack of appreciation by some who were especially striving to further higher medical education, of that which his experience with Fowler had taught him so clearly, namely, that a sound basis in the fundamental sciences, however desirable and necessary for him who would be a scholarly physician, was in no way a *short cut* to that experience, practical and human, which always has been and always will be necessary to make a good diagnostician, a good doctor, a good clinical teacher; that

no amount of learning can take the place of long, daily association with sick men and women, the constant practice of diagnostic methods, critical observation of therapeutic measures with living human beings, and a personal familiarity with the anatomical changes of disease gained by following one's patients to the necropsy table. Some seemed to fancy that clinical aptitude and authority could be gained, by a man with good fundamental basis, in a very few years. That was a sad misconception. He had seen some rather pathetic examples of good fellows who had spent too many years away from ward and patient and had discovered too late their error. Not that this disturbed him greatly; the pendulum never stops at the end of its swing; but he hated to see enthusiasm for a good cause hitch its wagon to a pendulum.

Twenty-five years after he had left the hospital he spent a few days at Cecil for the first time in many years. Fowler was dead. The two medical schools remained, each doing its special work. But to his surprise the jealousy and unfriendliness had vanished. He found men of one school teaching at the other, sometimes in both schools at the same time; he found students of one school seeking special courses under a noted man at the other. And the town was no longer divided, as it had been before, into separate groups. Incidentally he met a peculiarly attractive young fellow who was doing notable work at the medical clinic at Skipwith. There was something familiar about his face. Who was he?

He was the son of Dr. H., who in his day would have cut off his hand rather than enter that hospital. It was Fowler, after all, who had done this; his example had taught a generation of students tolerance and human charity.

The night before he left he dined with two internes who were about to enter into practice. He talked of Fowler, of his appearance, his charm, his brilliance, his wisdom, his skill, his learning, of what he owed him, and of what he had learned from him.

"Fowler," said Jones, "never preached and rarely offered advice unasked. What we learned from him we learned from the example that he set. He taught us by his example the dignity of medicine as a profession. We are a self-conscious lot, we English-speaking people, and we, at least the better of us, despite the rude and vulgar bragging of our newspapers, are embarrassed by praise. We don't like to hear people in our presence speak in too fulsome a manner of the virtues of medicine as a profession and laud the doctor as a self-sacrificing saint. We know it is n't true. But nevertheless we who saw him realized the beauty and dignity of the art of medicine, and what it does for them who give themselves to it earnestly and with a whole heart. No man can lead the life of a serious practitioner and meet his fellows as does the doctor, without becoming a better man. Fowler's acts spoke to us far louder and clearer than words. Here are some of the things they said:

"'Respect your profession and your colleagues. Hold your tongue!

"'Do not allow yourself to laugh lightly and to jest on medical subjects in the presence of laymen. You would not speak thus of your mother. Hold your tongue!

"'Do not allow yourself to enter into controversies on medical subjects with un-understanding people; it is useless and futile and will often deliver you and your cause into the hands of your opponents.

"'"Every man," says Sir Thomas Browne, "is not a proper Champion for Truth, nor fit to take up the Gantlet in the cause of Veritie: Many from an ignorance of these Maximes, and an inconsiderate Zeale unto Truth, have too rashly charged the troopes of error, and remaine as Trophees unto the Enemies of Truth; a Man may be in as just possession of Truth as of a City, and yet be forced to surrender; 't is therefore far better to enjoy her with peace, than to hazzard her on a battel; . . ."[1] Hold your tongue!

"'Never speak ill of a colleague. If he seem to you to have done wrong, if you disapprove of his actions, show it by avoiding him if you will, but hold your tongue! Nine times out of ten you will find there are explanations for his action of which you know nothing. If you speak, you become his enemy. You can no more associate with him and remain an honest man. Is it worth while?

"'Respect your colleague. Close your ears. Do not allow others to speak ill of your colleague in your

[1] Sir Thomas Browne, *Religio Medici*, Sec. vi.

presence. Generally they are mistaken. Remember that most doctors are honest men and decent fellows, even if you don't understand them. Hold your tongue!

"'There is nothing that poisons the mind like the spoken and repeated word. The reiterated word, be it true or false, becomes ere long a conviction, alike to him who speaks it and to him who listens.

"'Beware the power of the spoken and repeated word! The Christian Scientists know it. The German General Staff knew it; it was and is the whole story of their propaganda at home and abroad. An assertion, an accusation, a suspicion, repeated and reiterated, soon becomes a conviction. Hold your tongue!

"'Idle gossip, careless criticism may injure your neighbor; it always poisons you.

"'Be simple. Be yourself. Don't "pronounce." In the newspapers most doctors "pronounce," which means that too many of us come to deceive ourselves and believe in our own omniscience. Omniscience may not be a crime; it is a serious foible.

"'Remember how little you know. Don't be afraid to say you don't know. Don't lay claim to superior knowledge.

"'Don't judge your neighbor. Too often the ill you think of him is but the reflection of your own faults. "My son," says Marco to Guido, "each man sees in another individual that which he sees in himself; and each one comprehends that other individual in a dif-

ferent fashion, and precisely from the level of his own moral nature." [1]

"'Don't take yourself too seriously. Don't carry a chip on your shoulder. There is nothing so pathetic or so funny as a doctor with a chip on his shoulder. Too often it turns out to be a millstone. You are dealing with ill, difficult, often unreasonable people; but they are free agents. You have no divine right to prescribe to them a code of ethics. Their actions may disappoint you. They may pain you. Never let them offend you. A wise man has said, "A cad is one who, when he is not giving offense, is taking it, and . . . a properly behaved person never feels insulted because he never need." [2] If you are capable of taking offense and feeling insulted at what your patients do, there is something the matter with you. You have lowered yourself to the level of your unreasonable patient. If a patient wants to leave you and go to your colleague, he has a perfect right to do so. Help him and encourage him to do it if need be. If he has lost faith in you or does n't like you, you can't help him. You have no God-given proprietorship in your patients. They are their own masters. Send them on their way with your blessing; 'tis the surest way to get them back.

"'Commune freely and frankly and openly with your colleagues. Mingle with them in societies. Seek their

[1] Maeterlinck, *Monna Vanna* (Paris, Charpentier, 1902, 12mo.), p. 26.

[2] Herringham, *A Physician in France* (Edward Arnold, London, 1919, 8vo.), p. 214.

aid. Trust them in emergencies, and in the immense majority of instances they will merit your trust.

"'Medicine is a jealous mistress. You can serve her only with your whole heart. Leave her if you will, but don't attempt to divide your allegiance with rivals, religion, art, politics, however alluring or worthy they may seem in themselves.

"'The master word in medicine is work.'

"These were some of the things that Fowler's example said to us. They are hard to live up to and they sound like preaching, but — if you had seen him!"

"Doctor," said one of the boys, "Have you read 'Arrowsmith'?"

"No," said Jones, "I have not, but I will."

He read it, and lay back in his chair and laughed. "By Jove," said he, "I might almost have written that myself twenty-seven years ago!"

IV

The Significance of Illness

By Austen Fox Riggs, M.D.

Introduction

THAT a series of lectures on "Physician and Patient" should be offered to the students of the Harvard Medical School has a twofold and, I trust, a far-reaching significance. Such exercises have long been an integral part of teaching men and women the art of nursing; but that they should now become part of the medical student's training is indicative both of a marked advance in American medical education and at the same time of Harvard's leadership in this field.

Sometimes in the advance of science that which seems the bold forward step of a pioneer is a step even more courageous — a step backward to pick up some once highly valued truth, dropped carelessly and long ago in the hurry of the onward rush of new discoveries. It is in truth just such a backward step when, after decades of extraordinary advance in the science of medicine, the importance of the individual patient is so happily rediscovered. After all, it is he who benefits by our skill or suffers through our mistakes. It is he whose life, or health, or happiness is at stake. It

is its effect upon *him*, singly or collectively, which is the final test of the worth of any and every part as well as of the whole of medical science. In the crowded times of new discoveries and of the development of more and more accurate means of diagnosis, we may perhaps find our excuse in having forgotten the object of it all — the patient himself. However that may be, the fact is that, from about the time of Lister to almost the present day, forgotten he has been. During this period, the study of diseases, not of patients, has been the object of most of our best endeavor. But now the rediscovery of the patient as the most important item in the picture has changed all that and the new generation of physicians can now, at the very beginning of their careers, go forth with the brand new but very old-fashioned and sane objective of helping their patients to avoid illness, to overcome illness, or, failing this, to die with as little suffering as possible. To this end scientific methods, the laboratories, and all other means become the ready servants of the art of medicine. But the Art itself will be blind unless it is guided by an understanding of the individual patient and, furthermore, of the significance to him both of his illness and of his treatment.

To understand the individual, whether sick or well, has become then the first requisite of the wholly modern physician. That all-embracing physiology called psychology, which deals with the reactions of the individual as a whole, is the parent science to such understanding,

and I therefore recommend it to you as being quite as important as your indispensable anatomy and physiology. That part of it which deals with emotions is especially relevant to our present subject, for every human being is endowed with emotions and (I wish to call your attention particularly to this important fact) emotions are *primarily physiological reactions*. Upon this fact are based the following conclusions of great importance to the practice of medicine:

First: disease must, through disordered function, affect the emotions of the patient.

Second: emotions in their turn must, through modification of function, affect disease.

Third: treatment, likewise, must both affect and be affected by emotions.

Before taking up in their order these three conclusions let me describe briefly what is meant by "emotions."

As human animals, our first reaction to any perceived change in environment is emotional, that is, it follows a biological and physiological pattern called inherent or instinctive. This process involves a distinct change in the physiological, biochemical, and mental status. The latter is that part of the change which is usually labelled "emotion." Or one might say, emotion is what we *feel* of instinctive reaction. This feeling is always more or less distinctly pleasurable or painful. But the emotion counts more than as pleasurable or painful feeling, for it always carries with it a more or less strong impulse to

action, that is, expression. If this impulse is carried out unmodified or, at least, unconsidered, we speak of the action as impulsive or instinctive. If it is modified, or another action is substituted for it according to the dictates of intelligence, then the action becomes considered or intelligent to some degree.

Human animals, however, vary as to these two items. In the first place, some tend to over-react, some to under-react instinctively. Further, they vary in the relative strength of their specific instinctive tendencies. In other words, some people are more pugnacious, some more timid, some more aggressive, some more retiring than others, in response to any given condition.

In the second place, whatever their instinctive make-up may be and whatever degree of sensitiveness to its activities they may possess, they also vary in terms of their intelligence; thus they vary not only according to their instinctive reactions, but also according to their ability to modify these reactions. This variation may arise from a difference in fundamental ability to understand, or from a difference in experience and training, or from a combination of both.

A third variant in personal tendencies is that called suggestibility. This is the liability, widely varying in different individuals, to the uncritical acceptation of ideas. It is always present to some degree, greater in children and adolescents than in the middle-aged, and least in the aged. Roughly speaking, in any one individual and about any one subject its strength bears

an inverse ratio to the individual's specific knowledge of that subject. For instance, a layman is apt to be more suggestible than a physician in regard to a medical procedure.

Thus every human being may confidently be expected to react to illness or any other perceived change in his environment according to

(1) his instinctive and emotional make-up, including his general sensitiveness to these painful or pleasurable reactions;

(2) the degree of his intelligence, or in other words, his power, potential or acquired, to modify such reactions through understanding; and

(3) the degree of suggestibility he possesses specifically in regard to the given change.

In short, no matter what the disease or disorder may be, every patient is to some degree timid or pugnacious, sensitive or insensitive, intelligent or stupid; he is also to some degree ignorant or informed, and will react both to his disorder and to his treatment accordingly.

It seems too obvious to point out that, if only as a matter of differential diagnosis, — as an aid to evaluating the patient's symptoms, — a knowledge of these three items in his individuality is of the utmost importance.

A brief consideration of the emotional effects of certain items common to all illness will crystallize the practical aspect of this theme. The items to which I refer are Pain, Confinement, Disability, and lastly and most

important of all, the significance that all of these items singly and combined may have to the patient.

Effect of Pain and Discomfort

Irrespective of differences in individual make-up, pain or discomfort will have certain general effects on all.

In the first place, it will definitely increase the general emotional irritability. If the patient is naturally timid, it will increase his timidity; if he is pugnacious, it will increase that pugnacity. In short, sensitiveness, whatever the specific or habitual experience may have been, will regularly be increased by pain.

Its effect on mood is of course well known. It diminishes elation or turns it into the channel of irritability. It definitely and directly causes depression. The classical physiological responses to pain are:

(1) Increased muscular tonus, (2) generally increased psychomotor activity, (3) marked vaso-motor changes, and (4) not infrequently, sweating. Among other items are the still little understood changes in blood chemistry, endocrine activities, and metabolism. This, of course, is only the physiological side of the emotional picture. Perhaps these physiological changes constitute the actual specific basis of the emotion we feel in the presence of pain, complicated or not, as the case may be, by the addition of specific fear or anger according to one's particular make-up.

However this may be, the fact seems plain that pain has a specific effect upon the emotional status of one

who suffers it, and likewise that his response is more or less specific according to his emotional nature, his suggestibility and his intelligence.

Effect of Confinement

Inactivity, or better, confinement, is another aspect of illness or disability which calls out specific responses from the sufferer. By restricting the mental horizon, by forcing the attention to focus on pain, discomfort, or an abnormality of function, it produces at least a strong tendency to introspection. Of course, merely mechanical confinement of a previously active person is productive of discomfort both of mind and body, not to speak of the boredom of an active mind thrown out of its occupation. Inactivity also necessitates physiological readjustments which add their quota of disagreeable sensations to those of the illness itself.

Effect of the Significance of Disease

Far more important than any of the foregoing items inherent in disease or disorder, causing definite and unfavorable changes in the patient's emotional status, is what we may well call the *significance* of the episode *to him*. Indeed, if one includes a definite diagnosis of the individual make-up of the patient in the meaning of the term "significance," this one item may be said to contain the sum total of the psycho-therapeutic, if not of the whole therapeutic indication.

The emotional effect of illness will depend largely on this item, for though the actual condition, be it a fracture of an arm or pneumonia, is of obviously transcendent importance, its significance to the patient is far from being just the pain and discomfort which it may cause him. That alone will produce some emotional reaction, but that reaction is a mere spark compared to the possible emotional blaze of his reaction to the significance which his illness has for him. A mere whisper produces a very small physiological reaction through the eighth cranial nerve, much smaller than the loud, more painful sound of an explosion; yet, if that whisper signifies that you are about to be shot through the head, the emotional reaction will be overwhelmingly great and extremely painful; whereas, the loudest explosive sound, if you are sure that it only signifies a blast in a nearby stone quarry, can cause hardly more than annoyance. So it is with the pain or discomfort of illness. The absorbingly interesting question to the patient is, what is its significance? His emotional reaction will regularly be according to some such category as this:

What is the significance of these disagreeable symptoms?

Am I going to die or get well?

Does this mean a short or long invalidism?

For how long and how much pain am I to suffer?

Am I to be disfigured, deformed, permanently crippled?

Will this affect my earning capacity?

Does this mean that I must assume a burden of debt? Must I change or lose my job?

Furthermore, it is not the facts alone, but what the patient believes them to be and what he believes they mean, which constitutes their significance to him. Prognosis in the broadest sense of the word is what interests him, and whatever he thinks it and feels it to be, that is what he reacts to emotionally. To judge this significance, let alone to modify it favorably, one must know one's patient not just physically but individually. That is, one must know his temperamental and instinctive make-up, the degree of his suggestibility, roughly at least his intelligence quotient and his educational status, and, last but not least, his financial and economic condition. In short, in order to judge the extent and nature of any individual's emotional reaction to disease and disorder it is of the utmost importance to know his individuality on the one hand and, keeping that in mind, to estimate the degree to which the condition seems to him to threaten his physical, his social and his economic integrity. Only by some such approach to his personal problem can one apply the often sorely needed psychotherapy. Aside from whatever individualistic differences they may exhibit, a banker with a large assured income who has suffered a simple fracture of the lower leg obviously has a very different problem on his hands from that of a self-supporting woman suffering from the same or a very much lesser accident.

Individualistic Variations of Reaction

However, given the same social and economic status and also the same illness or accident, very wide differences in reaction occur in different individuals. This is due, as has already been suggested, to fundamental differences in individuality. Obviously a highly suggestible, intelligent, though ignorant and perhaps superstitious and timid person will not only react quite differently to the actual disorder, but also will find a different significance in it, from, let us say, a non-suggestible, equally intelligent, better educated and somewhat pugnacious individual. It is quite obvious that each of these two hypothetical cases will have a different instinctive reaction to illness; this reaction will again be modified differently in each case, according to the available intelligence; each will react differently to the pain and discomfort, differently to the confinement, and lastly and *most* differently, to whatever in each case is to him the significance, threatening or otherwise, of the illness.

Emotion Affects Disease

The converse of the first conclusion that disease affects emotion is almost a corollary and needs little proof, for, after all, change in organic function is the very basis of emotion, and consequently there can be no change of emotional status without a concomitant change in organic function. Ergo, emotional change must affect disturbed as well as normal organic function, either beneficially or harmfully to some degree or another.

Anger, fear or pain, as is well known, causes changes in the rate and character of the heart's action, in vasomotor activity, in blood chemistry, endocrine activity, in gastro-intestinal action, and in muscle tone.

It is clear that these changes, when they occur in the presence of diseases and disorders affecting any of the organs or so-called systems, must be either advantageous or disadvantageous.

For example, no man of experience would care to have a patient suffering from high blood pressure undergo a violent and prolonged rage. Nor would he care to have a case of severe cardiac disease subjected to paralyzing fear, nor in fact, to any other violent emotion. What anxiety on the part of the nursing mother does to the baby is another obvious instance, among many which could be adduced to point the moral, that emotions are by far too important factors to be neglected by any physician, no matter what his specialty.

Treatment Affects and is Affected by Emotion

The third conclusion of importance to the practice of medicine to be drawn from the physiological nature of emotions, is that treatment affects and is affected by emotion.

Entirely aside from any abnormal mental condition it is a fact that physical treatment itself is part of the situation to which a patient must adjust himself. He reacts not only to the disease but to the treatment as well; not only to the significance of the disease, but—

mark well — to the *significance of his treatment.* For no matter what is physically wrong he is always the sensitive, emotional man, the more or less suggestible "child of nature," and his treatment, whatever its physical effect, has to him outstanding emotional and intellectual values.

As good physicians you should never lose sight of this sensitiveness of your patients to all procedure. A process which to you is but an insignificant item of routine examination may appeal to them as something quite horrible, or at least inexplicable, and therefore full of dread possibilities. For instance, a basal metabolism determination which in itself need not be at all uncomfortable, but which is most suggestive of a general anaesthesia to many patients, may be entirely worthless if the patient happens to react with anxiety to it, no matter how well he behaves outwardly. His emotional reaction not only causes him discomfort, but the emotion itself will actually vitiate the result of the examination. It is not pleasant to have your nose clamped and to breathe into a rubber tube; like all other animals, man objects to having his breathing interfered with in the slightest degree. A simple explanation of the object and harmless nature of the proceedings will often save your patients unnecessary and sometimes harmful suffering. To take them as much as possible into partnership, is the moral to be drawn.

Environmental Effects

A patient's surroundings are to him physically agreeable in terms of sight, sound, and odor, or disagreeable. They are also emotionally acceptable or repellant to some degree according to their significance to him. To him they may be gruesome, they may be threatening, or they may be hopeful and encouraging. These elements are always for or against his welfare, and should not be neglected.

This applies as well to the personnel by whom he is cared for. A good-looking, attractive, friendly, interested nurse is as great an advantage as a homely, impersonal, uninterested nurse is a disadvantage.

Significance of Procedures

So it is with all procedures, diagnostic or therapeutic, which the patient undergoes. Every item has its personal significance to him. We must not forget that in taking a history we are not only subjecting him to a memory test, not only to a disturbingly introspective process, but are causing to pass in review before him many possibilities of familial and hereditary disease and weakness. A physical examination, likewise, may only too easily cause him to suspect, as *we* do, each one of his organs as it is examined. He may well wonder, has he this disease or that. Perhaps he is fifty, and as often is the case, has long dreaded the possibility of cancer, or apoplexy, or heart failure, or arterial sclerosis. Further-

more, we may, if we do not take care, introduce new suspicions.

Our therapeutic efforts also have special significance to him. How will this operation affect his life? Does it carry an immediate threat to life itself? Is he to suffer more pain and then be free from it? You may know the facts, but the chances are that without your help the patient does not know them, and they are *very* important facts to him. If he is not informed, he will guess at them and react emotionally according to his guess. To give such information in practical and helpful form is a part, and a big part, of common-sense therapy.

There are definite therapeutic objects to be gained by applying such knowledge of our patient's individuality and of his social condition, financial status, and so forth. They are briefly:

First, to avoid unfavorable emotional reactions,
Second, conversely, to foster favorable emotions,
Third, to build up favorable sentiments, such as courage and hope,
Fourth, to use favorable suggestion,
Fifth, to avoid adverse suggestion, and
Sixth, to gain intelligent coöperation, both in diagnosis and treatment, through mutual understanding and confidence.

In order to attain all or any one of these objects, the first essential is to understand the individual one is deal-

ing with, and that means understanding his instinctive personality, knowing roughly at least, what his experience, educational and other, has been, estimating with fair accuracy his intelligence, especially in terms of his educability, and last, but not least, knowing his economic status.

Application of Estimate of Significance of Disease and Treatment

Only on some such basis can one reach any really practical estimate of the significance to the patient of his disease, or of the probable significance to him of the proposed therapeutic procedures. This estimate, at least a helpful guide to diagnosis, is an absolutely essential guide to successful therapy.

The actual technique of applying our knowledge of the patient and his life to the care of him as an individual amounts to skilfully modifying every procedure to suit his particular emotional, intellectual, and financial need. To do this successfully, you must first *know* your patient and in this your personal attitude toward him is of outstanding importance. It is in misfortune that a "feller needs a friend," and illness is a misfortune. This fact is an invitation to make the relationship of physician and patient one of *friendship*, and it is an invitation which must be accepted if one is to measure up to the therapeutic opportunity. The wish to understand must precede understanding in order to lead to *sympathetic* understanding, and sympathetic under-

standing is as necessary to success as unsympathetic misunderstanding and contempt are destructive to it. Hence the importance of approaching the patient and his problem in the spirit of friendship. This spirit will show through the physician's manner even more than in his words; so will the opposite.

The highly depersonalized attitude of a scientist interested only in the intellectual problem presented by a nameless "case" does not appeal to a patient. This, too, shows through both words and manner. Even if this does no other harm, it at least robs the patient of his sense of identity, which, by the way, if he happens to be a ward patient in a big hospital, is already pretty well shattered. But this impersonal attitude actually *does* do other harm, for it repels confidence, puts an emotional dam where a bridge should be and thus excludes mutual and sympathetic understanding.

I once went to a great modern hospital to call on an old negro whose employer was anxious to get news of him. At the desk they told me he was in such and such a ward. So, arriving at the ward, I asked an interne where Sam Jackson was and how he was getting on. He evidently had never heard of him, so I described him as well as I could and added, "I think he has pneumonia." "Oh," said the interne, "pneumonia? There's a case of type 2, in the little room off the ward. Perhaps he's your man." We repaired to the little room and there was a gaunt, emaciated negro, lying with his eyes closed, the most utterly apathetic specimen of

weak humanity I had ever seen. He paid not the slightest attention to our entrance, though the interne was telling me volubly all about the bets that he and others had made on the case, how interesting it was, and incidentally how they regretted keenly from the scientific point of view that their findings could not be finally and completely cleared up as the patient was evidently recovering. The patient's room looked like a laboratory, there were flasks of litmus milk in various highly interesting stages of change arranged — a half-dozen of them — on a shelf. There was a portable blood-pressure apparatus, there was a tray of sputum bottles, and the urinalysis record was displayed like a series of banners along the side of the room facing the bed. Suggestive surroundings for an ignorant, lonely, and superstitious negro! Finally he opened his eyes and gazed without hope or interest or any visible change of expression at us and through us. Surely he was not asleep! I went over to the bed and said "Hello Sam, how are you?" Such a quick and complete change in the facial expression, in the look of his eyes, in the whole attitude of the man, I have rarely seen. From an apathetic, apparently hopeless automaton Sam became himself again, a friendly, companionable human being, possessing an identity of his own. "My that sounds good to me, 'Sam!' I have n't heard my name since I been here. Nobody knows me here. I been powerful lonely, but they're wonderful people here. They knows an awful lot." My calling him by his name was symbolic of all

that he had missed, especially in his convalescence, for that was the stage he had arrived at. He said as much when he told me quite simply that not once since entering the hospital had any one called him by name. He had lost his identity, he was merely the living test-tube. He had suffered abominably from loneliness. I do not doubt that my short call as a friend proved a powerful and immediate aid to his convalescence. There is no necessity for such un-human treatment. It is bad medicine. All the scientific interest in the world need not exclude the human friendly side; indeed, science, in this case, had very nearly defeated itself because it had neglected the emotional side of that very important person, the patient.

Honesty of purpose and determination to succeed stand out in a physician's attitude and create confidence and hope. Obviously half-hearted vacillation creates doubt and anxiety. That miserable self-protective process consisting of hedging on your diagnostic bet by making every other possible guess and sharing your doubts with your patient is as contemptible, and what is worse, as bad for your patient, and as catching as any other form of cowardice. What I am trying to describe is by no means a rare therapeutic crime but one I hope that none of you will ever be guilty of. I submit the following example to illustrate and, I hope, duly impress. A fellow practitioner called me to see a patient with him. She was a middle-aged woman of education and refinement. She had abdominal distress

caused by some chronic intestinal disorder. Imagine us standing at the bedside, the nurse standing by to assist at the examination, the patient looking expectantly from one to the other. To thoroughly disguise my confrere, let us say he was a country practitioner. He speaks, as with knitted brow he palpates the abdomen, "There is slight rigidity here but I don't *think* it is appendicitis," — the patient looks a bit anxious. "I think I feel the spleen. It may, of course, be typhoid but there is little if any temperature." The patient looks a bit more anxious and the doctor continues: "I wish you would see, Doctor, whether *you* feel any mass, — I think I feel something in the sigmoid region. There has n't been any loss of weight or strength, however." Now the patient is thoroughly apprehensive and who would not be? But the self-protective practitioner has covered his tracks; no matter what the outcome of the case, he has exhibited a diagnostic acumen satisfactory to himself at least, and one of his guesses, if worst comes to worst, will probably prove to be correct and he can say, "I thought that was the trouble. Remember I said so-and-so?"

As a matter of fact, none of his guesses were right, the lady had a small rectal polyp and was somewhat constipated. Inconsiderate self-defence defeated itself, for his patient remembers him only as a bungling alarmist.

Useful Sentiments to be Aroused

If we are to produce the useful sentiment of hope in our patients, we ourselves must be both hopeful and honest. If we wish to inspire faith we must not only be determined, one hundred per cent determined, to do our best, but we must have faith and show that faith in the integrity and ability of our patient. If we are to inspire courage we must have it ourselves. These invaluable emotional aids or their harmful opposites are absorbed by our patients more through intimation and unconscious imitation, more by indirect suggestion than through didactic teaching and learning, and thereby hangs the great importance of suggestion in all forms of treatment.

Suggestion to be Used

Suggestion plays a part all the time from the very first contact to the last. It acts rather through *how* a thing is said than what is said. A solemn and anxious manner will obviously neutralize completely an otherwise cheering phrase such as, "First rate! You are doing well." Whereas the suggestive effect of a satisfied, confident and cheerful manner will easily carry off a literally cheerless remark such as, "Not so Bad."

Adverse Suggestions — Avoid

To use suggestion and avoid adverse suggestion is largely a matter of that rare sense, common sense, and tact. Guided by sympathetic understanding, reinforced

by the technique of honest tact, adverse suggestion can be avoided throughout all diagnostic and therapeutic procedures. The full advantage of favorable suggestion can likewise be secured through these same qualities by the simple method of emphasizing such diagnostic results as are distinctly favorable — strong normal heart, a large lung expansion, for instance — and doing this same thing in therapeutic procedure by pointing out the results already attained or surely to be expected.

Prognosis

The importance to prognosis of understanding one's patient in psychological and situational terms is almost self-evident. Most people get well, but obviously he who is hopeful recovers more quickly than he who is despondent. Can you doubt the difference in prognosis for one who can easily bear the expense of an illness or an operation and one who must assume an almost hopeless burden of debt in exchange for his medical or surgical relief? Does not an eager ambition to get back to a delightful and satisfying life give a better prognosis than the dread of a return to a sordid and half-starved monotony? Does not the possibility of changing the mode of life to one minimizing a residual handicap give a better prognosis than the necessity of continuing to live the very kind of life which exaggerates the handicap or, because of its specific effect, threatens life itself? Or, finally, may not the illness itself with its escape from everyday life seem, or even be, preferable to such a life without disability?

These are a few of the many significant items which may materially affect prognosis. They challenge the physician's ability both as a physician and as a man, and he should never forget that prognosis is the aspect of illness which above all others is of transcendent importance to the patient.

Conclusion

Considering all this, there can be no doubt that an understanding of what the significance of the patient's illness is to him, and what to him are the significances of the procedures he undergoes, constitutes a most important element in diagnosis, an essential guide to treatment, and is absolutely indispensable to prognosis.

I trust that this discussion will have helped you in some degree to a fuller and more practical realization that the one primary and fundamental essential in the care of a patient is to understand him, and his life, in terms of his human needs, and not to treat him as just the incidental locus of a disease.

V

Some Psychological Observations by the Surgeon

By Franklin G. Balch, M.D.

In some ways the early method of acquiring a medical education had advantages over the present day. The student learned much besides medicine and surgery while making the rounds with the doctor with whom he was studying. There was little medicine many times, and many weary hours waiting for the doctor, with no interest outside of the student's own thoughts and attending a very docile horse; but with some men it meant an education from the patient's point of view which is at present impossible to get. The student was taught to use his powers of observation intensively. There were no instruments such as the modern blood-pressure apparatus and blood-counting slides, and until comparatively recent years, even the use of the stethoscope and examination of the urine were quite exceptional proceedings. The doctor learned much from the character of the patient's pulse, and I dare say that some of the more acute observers knew as much of a patient's condition after one of their heart examinations as does the modern doctor after putting his sub-

ject through all the various procedures of the present-day office. The tongue, too, was a very accurate guide for many men in the diagnosis of stomach troubles. I do not mean to say that in these respects we have not advanced far, but that in that advance we have left some useful tools by the wayside, abandoning them for more modern ones.

The patient was always in the foreground with little or no laboratory findings to help.

It seems as if we might be coming back to the view that the student should very early in his course be thrown in contact with patients, before he has had so much of the theoretical end of medicine pumped into his system that he has come to regard diagnosis as the only important side of the profession.

Our patients come to us for help in their troubles and care little what the operation is done for as long as they get relief. Of course, there are very many things to consider, but I always feel disappointed with myself when I have done a palliative operation with the result that I have simply prolonged the patient's suffering.

To my mind eating three meals a day for an extra month or two is not worth while if, to relieve an intestinal obstruction, for instance, I have had to do a colostomy in a man who already has metastases in the liver. In the same way a palliative operation for carcinoma of the breast has always got to be considered from all angles. But perhaps all this does not belong to my part of the subject.

When I was asked if I would talk to you on something connected with the psychology of surgery, I promptly said I knew nothing of psychology. Being assured that it was a subject as broad as the earth, as high as the heavens, and as deep as hell, it seemed as if I must have acquired something in the course of about thirty-five years of practice that was not taught in books and yet would fit into these boundaries.

Perhaps our initiation into the mysteries of psychology may be said to start as a medical student when we first begin in the laboratory to study chemistry. If you have not found some of your class who have become fully convinced that they were headed straight for the graveyard with Bright's disease or pulmonary tuberculosis, the present-day medical student is different from those in my day. There is no more startling example of the statement that a little knowledge is a dangerous thing.

As you go on further you find that a temporary albuminuria or even a cough with expectoration is not necessarily fatal. You have probably heard the story of the practical joke played on a perfectly healthy motorman. Several of his friends conspired to try the effect of suggestion on him. He started on his day's work as well as ever. As the day went on and one man after another told him how badly he looked, the effect was remarkable. At first he laughingly denied that he was ill, then got indignant, but before noon he was at home in bed.

Perhaps nowhere is the effect of suggestion more marked than in medico-legal cases. A man is badly hurt in an accident, say with a strained knee. He is in bed for a while and as the damage is repaired he gets up and begins to walk. If he knows that his ability to get employment again depends upon himself alone, he makes every effort to get ahead. The swelling and slight pain and disability are disregarded and in the course of a month he is back at work with very little thought of his misadventure.

Now bring in the question of compensation and the responsibility of another, and the picture changes. His lawyer tells him perhaps that if he stays in bed his employer or someone who owned the property where he was injured can be made to pay what seems to him a large sum. He forgets that this money goes largely to the lawyer, but as Kipling says, "that is another story." The leg is kept quiet, perhaps in a cast, when he ought to be using it, and in a few months he may have acquired a really permanent disability.

In Massachusetts it is now nearly three years before a case of that sort comes to trial, and it is easy to imagine the amount of permanent damage which can be done in that time.

Is this dishonesty on the patient's part? In some cases, yes, but often it is merely the result of conscious or unconscious suggestion on the part of others. The pains of beginning motion are magnified until they assume a part entirely out of proportion to their real value.

A person may be perfectly honest and yet fully convinced that he is utterly unable to bear his weight on that leg. Long after the litigation is settled many of these people will be incapacitated, some by a real but many by an imaginary lesion. It may be months or even years before such a person is able again to take his place in the working world.

Some cases are distinctly and intentionally dishonest. One of our celebrated Boston neurologists was testifying in a case once where a man had received an injury of the shoulder. The patient claimed that he could not raise the arm from his side and could only use the forearm. The doctor asked him a number of questions in rather rapid succession and then said, "How high could you raise the arm before the accident?" "Up here," said the man, extending the arm well above his head.

In another case a friend of mine suspected that the plaintiff was a malingerer. It was an eye case but one in which examination of the retina gave no real testimony as to whether the patient could see or could not. The patient claimed to be blind. At the noon recess he started out holding on to his guide's arm. My oculist friend took somebody else for a witness and followed him. They went down from Pemberton Square, across Scollay Square and then started down Hanover Street. They had not gone far when the supposed blind man, feeling himself perfectly safe from observation, slipped his arm out of the guide's, started across the street, and dodged down into a saloon. The facts were reported to

the judge and that case was ended. Fortunately these are not common.

I have seen so much of this that I believe it would be far better for a man to settle up and get to work in almost every case. The mental, moral, and physical effect of prolonged litigation far offset any verdict he may get even if the bulk of the money comes to him.

The World War brought this out very strongly. I was chairman of a disability board in a hospital in Toul. Before the Armistice almost every man was eager to get back to his own outfit. They were all perfectly sure they could walk off with a forty-pound pack and travel any distance even though hardly able to stand long enough for an examination. It required close watching to stop some of them from going A. W. O. L. when they could hardly have gotten beyond the next village. With the Armistice, this changed and many of these men were only too glad to be kept in the hospital and finally be invalided home.

One of my officers had as an orderly a pretty thoroughly convalescent negro who had been a Pullman porter. Some months before we entered the war he had hurt his foot, but if it bothered him at all, he said nothing of it, having been sent to us for dysentery. He was a most amusing chap, an excellent orderly, and had a wonderful faculty for getting out of scrapes. One day the X-ray officer took a plate of his foot which showed an old fracture of a metatarsal bone — even then the foot did not bother him.

It so turned out that he went to Toul one evening, got caught by an M. P. in a forbidden portion of the town, having taken considerably more French wine than was good for him. Owing to his exalted state of mind he had the temerity to talk back to the officer who, unfortunately for him, came from Georgia. As a result he was court-martialed and ordered to a prison camp. What was the surprise of one of my officers some ten days later to see him limping by our camp in a hospital convoy bound home. He had promptly developed lameness, been X-rayed, passed upon by another medical disability board and invalided home.

I don't think in his case it was the suggestion of the X-ray, but he had promptly used that knowledge when it would help him and had most thoroughly fooled that disability board.

I could give you numberless examples of this mental attitude in war times, but what interests us now is peace time, and if we are looking for it, it is just as conspicuous here.

As house officers and for some years after, we seldom got appendix cases on the surgical side until there was a large abscess. We house officers, perhaps unconsciously, used psychology to effect an early operation. One of the visiting medical men, an excellent diagnostician and an authority on appendicitis, was so constituted that he generally took the opposite side. This was especially so when a house officer (we were all called Mr. in those days to show us where we belonged), held

an opinion that a patient should be operated upon. Several times have I secured consent for operations when the prospect seemed dark for getting one, by the simple expedient of appearing to see only the advantage of delay.

As years have gone by and the public as well as the doctors have come to recognize the advantages of early interference, the surgeon is placed in the anomalous position of having to advise against operations for many "mental appendices." The father of a patient said to me a short time ago, "I shall be glad to have it out anyhow whether it is inflamed or not as it might go bad some day."

So it might, but in many cases where the diagnosis is made by the patient or, more often, by his friends, an occasional mild cathartic or a little more attention to diet would have avoided anything more serious.

An unnecessary operation is very seldom a cure. We may see an occasional patient where it is the only thing which will arrest a chain of symptoms, but such cases are very rare and we must always bear in mind that where we replace a set of vague symptoms by the definite discomfort of a wound, we are apt to leave behind us a lot of adhesions which will furnish the excuse for still further operations, until our patient has all her or his removable organs in a bottle and is left a chronic invalid.

The first so-called interval appendix I ever did in private practice was such a case. The family doctor

had tried all he knew on a neurotic young woman and called me to a neighboring town to operate for what he described as a very definite chain of appendix symptoms. Knowing the doctor less well than I afterwards did, I removed the appendix, which seemed to me quite inoffensive from a pathological point of view. The woman later had first one tube and ovary and then the other and then the uterus removed. Later still her gall bladder was taken out and each time her condition was worse than before. Fortunately it was before the days of X-ray and gastro-enterostomy or she would probably have had that added to her troubles. Each time a new man operated and when I last heard from her she was a hopeless invalid, with, probably, ptosis, an ill-balanced mind, and indulgent and not too sensible parents as her real troubles.

An article in a New York Sunday paper on appendicitis brought me another early case. My patient digested all the symptoms and learned them by heart. He then proceeded to have them all — first only by day; but when he finally took to calling me out of bed at night, two or three times a week, I took out a mental appendix. Being ordinarily a sensible person, it cured him.

You should always bear in mind that a live patient is better than a perfectly finished operation. I have known cases where addition after addition was made to the operation until the patient succumbed to the shock.

One of the biggest problems in medicine is just how much to tell a patient. There is no question in my own mind that you must tell a patient the truth, but you want to be *mighty sure* it is the truth. You can hardly do a more cruel act than tell a patient he has tuberculosis of the lungs when he has perhaps been left with symptoms suggesting it after influenza or pneumonia. The same is true of cancer. In the first place, I never use that word if I can avoid it. To the layman it means almost a sentence of death, and to take away hope when we have simply removed an epithelioma is inexcusable. Some people want to know everything. If I have bad news for them, I sometimes put it to them in this way: "Now are you perfectly sure that you want to hear everything? It cannot do you any good and might make you very unhappy. Why not let it go that the operation is over and that everything humanly possible has been done to help you? Even if I told you you had some incurable trouble, I might be absolutely wrong. I have felt sure at times that I had operated on an incurable condition, only to find later that I was entirely mistaken." Sometimes you can get away with it. You never want to be sure that because you think a thing is carcinoma it necessarily is so. I operated for what I had supposed to be appendicitis. There was a great mass involving the cecum and the lower part of the ileum. It looked like cancer and could not be removed. I took out the appendix and side-tracked the growth by doing an anastomosis between the ascending

colon and ileum. I told the patient's family the case was hopeless. All the symptoms promptly subsided and years afterward I heard of the patient, a trained nurse, as perfectly well. What I had taken for carcinoma was tuberculosis. Fortunately for her own peace of mind, the patient had never pinned me down to a diagnosis.

Again it is impossible always to be sure of the diagnosis of carcinoma of the upper rectum or lower sigmoid even with an operation. The growth is hard to bring up into view in some people, and without a microscopic examination the diagnosis between diverticulitis and carcinoma is sometimes impossible.

For your own protection, it is essential that someone of the family know all of the story. It is not necessary to give them every possible diagnosis that you can think of as if you were making a diagnosis by elimination. That is not why you have been called in. Give them what you think is the most probable trouble, and give it in the most simple terms that you know. I have often thought that a man's real knowledge of a case was in inverse ratio to the number of medical terms he used in describing it. Dislocated vertebrae, which no one can see and an X-ray cannot show, certainly cover a multitude of doubtful situations for an osteopath.

We people of Boston are said to like to be fooled more than the rest of the country, and judging by the various waves all the way from Witchcraft to Christian Science that have swept over New England, this would seem to be so. And yet, most of them have good. I

shall not forget the help I got in one Christian Science case from the patient's faith in her healer. It was a fracture of the upper end of the humerus. They were most helpful and said they recognized that it was something they could not cure. The healer did not stay in the room. Now you cannot reduce a fractured humerus without pain but the patient said she had none. Finally she fainted, and I quickly got the bones in position before she came to and fortunately they locked. She declared she had only felt sleepy and said how foolish she was to act so. Only once did she call on the healer for help. She responded, "I am helping you, my dear, but you must help yourself." They did not seem to like X-rays, probably as being too suggestive, but in every other way they were most coöperative and the result was excellent.

In that case the mental attitude of that woman helped her enormously, and all through her convalescence she was never uncomfortable. No splint needed more padding, no bandage was ever too tight, and her help in moving the arm when the time came was a great advantage. I mention this case as an example of the aid of a proper frame of mind, however that frame of mind is brought about.

They are not all like this. A dentist with hemorrhoids refused to go to a Boston Hospital but insisted upon one in the suburbs because he said he knew he should have pain and he did not like it and was going to have a lot of morphia. He was afraid one of his healers would come to see him and find it out.

An early experience impressed me very strongly with the inadvisability of talking too much to impressionable people even when an apparently unnecessary operation had been done.

A woman was admitted to the ward, when I was in charge, with a tumor of the breast. She was a very sensitive being, with a horror of all operations and with a nearly insurmountable repugnance to such a mutilating procedure as a breast amputation. It apparently was carcinoma. The surgeon assured her that a radical operation was absolutely necessary and after much persuasion she finally consented. The breast was removed and several glands dissected out of the axilla. The pathologist reported tuberculosis. The surgeon laughingly told her that he had done an entirely too radical operation, an opinion in which he was undoubtedly wrong. He utterly forgot or disregarded the mental effect on a nervous woman. From a surgical point of view she did well, but was a nervous wreck, spent the next year in a nervine hospital, and for the rest of her life felt that she had been terribly abused and subjected to an unnecessary, mutilating operation.

When you have examined many women and found that the position of the uterus in many of them is not more important to their general well-being than their manner of dress, perhaps less so, you will not tell every time you find a retroversion. Like as not the next time you examine, you will find it in a forward position. Without symptoms definitely referable to its position,

who can say that one is more "normal" for that patient than the other. If you tell, you may have a hopeless neurasthenic on your hands who will lay every ache and pain and queer feeling to the position of that uterus. If you can reconcile your conscience to it, you can probably have her to fit pessaries to, or do supporting operations, for the rest of your days. The same is more or less true of a movable kidney. A person can have the organ far below its usual position until he, or more often she, knows it is low and then your and his trouble begins. So it is with the chronic urethritis. These patients can be kept worried and returning for treatment for months after they are really well physically. These are all things that you will discover for yourself in time, but if you can start out with this knowledge, it will add greatly to your value as a real doctor. Mercy knows there are troubles enough in the world without conjuring up imaginary ones.

A tendency of the present day is to lay too much emphasis on laboratory findings as distinct from the patient. You begin to think of a man as one hundred years old the minute he begins to tell you how much better they used to do these things in his day. In fact it is somewhat dangerous to tell how they used to do things at all, let alone how much better. None the less I will take a chance.

Take the matter of X-rays, one of the greatest helps to the doctor that has been discovered. It is interesting in looking over examination papers to see the first

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thing to be done in the treatment of a fracture put down as "have an X-ray taken at once." Fractures were treated before the discovery of X-rays and some very good results obtained. Present-day results are undoubtedly better anatomically in some cases than they were ten years ago, but don't be too much upset if you cannot get perfect X-ray alignment. Your functional result may be just as good without it, and after all that is what interests the patient. If, however, the X-ray does not show perfection, both you and your patient will be much happier if he does not see the plate. He can see what he calls a poor position, with the ends of the bone touching but not in perfect alignment, but he does not know as you do that a year hence it may be hard to discover where the break was. You do not deceive him at all if you tell him he is going to have a very good result.

The same is true of ptosis. Only a few years ago when we first discovered by the aid of X-rays the various different positions in which a person's large intestine was draped about his interior, we kept thinking that every variation from the normal of the textbook must be a cause for symptoms and many and various were the operations devised to correct these supposed abnormalities. Most patients were worse after them than they were before, and practically all the operations now have fallen into disrepute and disuse. So it is with adhesions. That word is used to cover a multitude of sins. Of course, viscera may become adherent to each other

or to the abdominal wall and often so in such a manner as to cause unpleasant or painful symptoms; but there are certain symptoms which follow almost every abdominal operation which may be due to adhesions but which are best left unnoticed. Before long the patient gets used to them and forgets them. Every time that we operate to relieve adhesions which are causing slight inconvenience, we are, of course, liable to replace them by adhesions which will give acute symptoms. It is much better to persuade your patient that though they are slightly uncomfortable they are of no great importance and he or she can perfectly safely forget them. In this way you accomplish a benefit far greater than you could have by operation. If you are in doubt in a case, do not hesitate to ask for a consultation, and if the patient or friends are in doubt, ask for it even more quickly. If you ask for a consultant, you will probably get the man you want and not have someone suggested to you who is the last person in the world whom you would want to call in. In many cases you will not get a thing out of further advice yourself, but at times you will get great assistance and almost invariably the mental effect on the patient is good. You also divide responsibility. When a thoroughly capable man has watched a case for some time, he probably has formed an opinion which ought to be more nearly correct than that of a man seeing the case for a single time. Usually a patient will pull himself together for a new man and appear better than he really is. This is apt to deceive

a doctor into giving a prognosis better than the circumstances warrant. Secondary operations are often a mistake and occasionally take away what little chance the patient had of recovery, but I shall never cease to regret one that I did not do. After a hysterectomy the patient did well for three days and then sneezed badly. A short time after, she vomited. The wound looked perfectly well, but as vomiting continued, I called an older man in consultation. He laughed at my fears and told me I was unduly alarmed. The family thought I was over-anxious to open up the abdomen and nothing was done. The patient died, and upon opening the wound we found a tiny nip in the small intestine where about half the lumen had squeezed in between the peritoneal stitches with the sneezing. It was the only trouble.

I do not tell you this to prejudice you against consultation, which I thoroughly believe in, but only to warn you that if a consultant does not agree with you, you must not therefore reverse all your treatment without talking it out thoroughly and viewing it from all angles. Don't take another's diagnosis when you are called in consultation until you have been over the whole ground.

There seems to be a growing tendency among patients and their friends to talk over other patients. Not long since one of the patients in a large private hospital greeted her nurse in the morning with this: "Never mind washing my face; run out and see if you cannot get me some nice gossip. There was evidently something

going on last night as there was a lot of noise." And the nurse, nothing loath, went out and did it.

If there is one thing more than another that will destroy a patient's faith in you, it is to know that you are discussing his or her case with others. What a patient tells you, or what you find out about him, is for yourself alone and no doctor or nurse should violate that confidence. Fortunately for me, I early learned that lesson in a most kindly way from Dr. Arthur Cabot. For seven years I was very intimately associated with him and I have often said that to him I owe any of the good habits in medicine which I have acquired. Do not forget that the average layman takes an entirely different view of some things pertaining to surgery from what we do. A little blood on a pair of white duck trousers would not worry a doctor or a nurse at all, but it might be enough to send a patient's friend into a dead faint, and at any rate it is one of the things which we should avoid, ever to offend a patient by sights, sounds, or smells which are intensively suggestive of surgery.

Furthermore do not take any chances that a patient may hear what you think about him by discussing the case in the entry. They may not hear what you are saying but what they imagine is even worse. You may be talking over diets or something entirely apart from the patient. That is not the point. Your patient is disturbed. So also with patients under a local anesthetic. Unless thoroughly narcotized, they are very keenly

alive to all that is said and done about them, and we may inadvertently let fall some word which they will never forget.

And so, again, with patients under ether. You cannot tell what they can hear, and often when apparently fully under, they realize all that is going on. That error was also brought home to me years ago.

I was etherizing a patient for a low forceps. After a few moments she was relaxed and was perfectly quiet. I said to the doctor, "she is gone now" meaning, only that she was fully under. What was my surprise later, when everything was over, to have the patient turn to me and say, "Doctor, don't ever say that again about a patient as long as you live. I knew and heard everything but I could not move hand or foot and I thought you meant that I was dead. It was horrible!"

And now let us turn for a moment from the impression produced on our patients to impressions produced upon others.

Very early in your medical career, you must learn that in case of doubt the golden rule is a mighty good rule to run by. The only doctors who never do anything wrong are those who do not tell the truth and those who have no practice. Yet we are often very harsh and very careless in our judgments of others. Because a doctor with none of our modern facilities of X-ray and laboratory has not arrived at the correct diagnosis, it is no excuse for a young house officer to say to the patient, or in his hearing, that some country doctor

has made an awful mistake. The chances are nine in ten that with his facilities he has done well. I take off my hat to the country doctor. He works hours often under the most trying circumstances that would make a labor union man hold up his hands in horror. A careless word of a house officer or nurse may sow the seed for a law suit which will take all the accumulation of a lifetime to satisfy.

A short time ago, I nearly had such an experience myself. A chance remark of a young nurse laid the foundation for that suit. A septic case in the hospital had a large slough removed from the wound. A nurse remarked that it looked like a sponge. The patient formed the conclusion that it was a sponge and brought suit. He had an honest lawyer, who when convinced that no sponge had been left in, gave up the case. He easily found a less scrupulous man and but for the fact that the case was thrown out of court by the statute of limitations, I should have had to defend this suit, and very possibly have been unable to persuade the jury that the verdict should have been in my favor. The man was probably honest but densely ignorant, and that one careless remark had planted the seed for a lot of trouble.

Among ourselves, it is less harm to discuss mistakes, and it is from our errors and those of others that we learn, but it is a very bad habit to be always criticizing the work of others and I advise you strongly to avoid it. To hear some groups of men tear another's reputa-

tion to shreds, you would think some of our ablest surgeons were not able to make the simplest diagnosis.

If the pronoun I has occurred very often in these remarks, it is not because I am egotistical but because I am trying to give you some of my personal experiences. Please be as charitable to me as I hope you will always be to your fellow practitioners.

VI

Human Nature and its Reaction to Suffering

By Lawrence K. Lunt, M.D.

THE word "patient" is derived, as you know, from the Latin "patio" meaning to suffer or endure. Hence it is used in connection with a sick person, as illness is suffering and has, in some way, to be endured. Yet in one standard dictionary "patient" is defined as (1) "a person undergoing treatment for disease or injury"; (2) "one who or that which receives external impressions; anything passively affected"; (3) "rare — a sufferer." So this dictionary sets forth, all too accurately it must be admitted, a frequent medical attitude toward the patient. That the patient is a sufferer, it states, is rare. But ask any patient or be one yourself, and you will find that to a greater or less extent every single one is a sufferer. It is that fact — for it is a fact, the dictionary definition to the contrary notwithstanding — that motivates medical practice. Without that knowledge, without that realization that every patient is a sufferer, you cannot be truly successful in the care of your patient.

Most of us grow up with the idea that illness is principally a matter of some physical disorder; an invasion

of the body by some pathogenic bacteria, or other noxious agent resulting in transient or permanent physical incapacity. To children, illness means a pain in the "stomach," usually with vomiting and perhaps diarrhoea. And the idea may include the sensation of burning up with fever, and the presence of some skin rash; or acute pain in some part of the body. The most acute physical suffering that we have had leaves its mental pictures labeled illness, and always we think of illness in terms of physical suffering. It is not until our experience has widened considerably that we are forced to recognize the fact that illness cannot be expressed in physical terms alone. It is not until we have "grown up" in our understanding of the way in which the human being is put together that we realize that there is an aspect of illness quite as important, and often vastly more important, than the physical aspect. You know to what I am referring: the mental aspect.

The physical side of illness must be understood. You can never be too well grounded in your knowledge of the many agents of disease, how they act on human tissues, how the tissues respond to them, how to treat the results and, as far as possible, to know fully all the preventive measures against disease. Such great advances have been made and are daily being made in the knowledge of the causes and prevention of disease that the attention and energies of medical students, teachers, and practitioners very easily become entirely absorbed in the diseases themselves, and the patient, the sufferer,

he who has to endure the disease, is forgotten. He becomes an interesting spectacle, merely the stage of an action, the convenient location of a battle which in itself is tremendously interesting. It is apt to be forgotten that this battle is taking place in a sensitive and complicated organism, in a living creature who is feeling something beyond the physical discomforts and pains. We overlook too easily the universal truth, that with physical suffering there always goes, to a greater or less extent, mental suffering.

Having attended this school myself, I am perhaps prejudiced when I say that there is probably no place in the world where one is capable of getting a finer or a fuller knowledge of medicine in all its aspects. You have been crammed full of information from all the fields of medical knowledge and have acquired an idea of the vastness of each field. But our school, as others, has in the past been swept too much into the tendency of looking on illness as primarily a physical thing. Now, thanks to the broad-minded vision of its faculty, it is pioneering in bringing into proper balance the relation between the mind and the sick body, so that now by a better coördination in your curriculum you can see to some extent the part that the human mind plays in illness, and therefore you have the opportunity of starting your medical career with a more comprehensive idea of that closely interacting relationship. I wish to reëmphasize that your success in the art of medical practice will be measured not only by your knowledge

of disease processes with your skill in the application of that knowledge, but also by the application of your knowledge of human nature and its reaction to suffering.

It is my function this afternoon to focus your attention upon the importance of the latter aspect of our art. What are some of the outstanding features of this aspect?

In the first place, let me remind you that whether he be in your future private practice or your present practice in the out-patient departments and hospital wards, your patient *is a sufferer*. That this suffering is not only physical but also mental. You cannot clearly separate the two into distinct and different entities; the one shades into the other. There is no physical disturbance without its mental concomitant; there is no mental upset without some parallel physical disturbance. The most we can say is that the trouble is primarily one or the other. To substantiate this you can turn to the fundamentals of neurology and physiology and add a little common-sense observation of yourself and others.

Along with the realization that your patient is a sufferer is the equally important fact that *he is a human being*, basically built along the same lines as you yourself are built. The general features of his skeleton, his muscular system, the distribution of blood vessels and nerves, the body chemistry are similar to yours. And, moreover, he has the same general underlying

impulses, drives, fears, hopes, ambitions. True, your chief ambition is to be a successful doctor, while his may be to win a crap game; he may fear that his child won't have enough food to live on and you may fear your next examination — quite different objectives, but the same underlying forces.

It is convenient to have at least some general conception of the human being and his nature, but wise *not* to have that conception too fixed, as you will probably find it necessary to enlarge and change your ideas and amplify them in accordance with your own experience. Let me present to you a brief and general framework on which you can build a useful conception. This framework is by no means dogmatic or final; it will not be unfamiliar to you and it may very likely be the one you already have. I believe, however, that of necessity in our medical course we have too little time for attention to other than the myriad details that are presented, and, therefore, most of us do not stop to make any very clear-cut formulations about the human animal.

This creature is a compact, intricately and beautifully coördinated and sensitively responsive organism in contact with the world about him and reacting constantly in different ways to the continuous changes to which he is subjected. A little more elaborate definition of life than the perfectly good one that it is "just one damned thing after another," is that it is a continuous series of adaptations to the constant changes taking place in the environment. The living creature is able to make these

adaptations by virtue primarily of that system within him whose especial business it is to adapt, to coördinate: namely, his nervous system. This system is the controlling factor in adaptation. Our interest in the nervous system in this discussion is not in its anatomy but in the manifestation of its activity — in its methods of controlling the adaptation of the whole individual.

The simplest method is the *reflex action:* the mechanical response to a stimulus — this is the groundwork of all adaptation. By means of this type of action, the oldest part of our nervous system controls the basic bodily functions with some degree of independence. That the independence is far from complete is too well known to merit discussion. But the application of the fact in dealing with illness, especially those illnesses that are primarily nervous, is not made fully enough. Reflex action occurs also, as you well know, over the newer, voluntary pathways; and over these pathways we build innumerable new reflex-like reactions, mechanical responses, that are called "conditioned" or "learned reflexes," and in this way we are enabled to increase the range of mechanical adaptability.

Unless we are among those whom McDougal calls "the deniers of instinct," we can take as the next higher method of adaptation the instinctive response. In this type we find the individual as a whole, not just in part as in reflexes, responding in some specific, inherent, predetermined fashion. We enter the world with latent capacities to act in certain ways under certain circum-

stances. Gradually as we develop, these specific capacities show themselves; we run from things that have proved to be painful, we investigate things that have aroused curiosity, we develop an interest in the opposite sex, we get angry when frustrated. As a part of this type of reaction there is the emotion. Each specific method of instinctive response has as its impelling factor a state of preparedness for action, — a state of mind *and* body, — the emotion. The instincts with their emotions have been called the source within the individual of all his actions. This is a useful concept and one which helps to explain, and therefore helps us to understand, human behavior in health as well as in disease. These springs of action exert strong drives within us; they release energy so to speak, and that energy demands expression. In the immature human, be he child or adult, the energy is used in crude, uncivilized behavior true to the primitive, instinctive tendencies. In the mature human, however, this energy is guided by another factor, the intelligence, which lends its name to the next higher type of response — *the intelligent response*.

The distinctive features in this type of behavior are a certain degree of controlled hesitancy and then choice of action. The instinct demands immediate action, the emotion mobilizes energy in preparation for action and seeks channels for release; but if the primitive methods of release are deliberately inhibited and a choice made which is more effective than the primitive expression,

thus modifying the latter, the behavior can be called intelligent.

There is one more factor in the human being that modifies his instinctive demands and thus elevates him a little further above his nearest animal relatives, and that is his spiritual, ethical, or moral quality — or whatever you wish to call it. The basic instincts serve the individual primarily, and secondarily the race. The intelligence may serve either, but the "ethical sense" is primarily concerned with the individual's relation to the other fellow. Each of these higher types of behavior embraces or includes the lower; so you can if you will, visualize them diagrammatically as four concentric circles, reflex the centre, surrounded by instinct, this in turn circumscribed by intelligence, and on the outside the ethical sense, each depending on the integrity of the others to ensure effective and satisfactory action.

The majority of individuals have a sufficiently healthy body and mind to get by the ordinary stresses and strains of life. Mentally they are well enough balanced to make reasonably good, if not perfect adaptations, so long as their health and happiness are not threatened too seriously. Many of them behave very well in the face of moderate threats and some in the face of serious obstacles to their welfare. These will not constitute much of a difficulty in your practice and will usually survive your best efforts, and often cheerfully and forgivingly even serious blunders. But these are the minority of those who will become your patients.

Unless you ally yourself to a busy consultant who gets only the most serious cases, or jump suddenly into fame as a consultant yourself, the patients who come to you will for the most part not be very seriously ill, from the point of view of imminent death. It will not be with your practice as it is in the hospital wards. When you leave the hospital, — or even, if you are unfortunate enough not to have a hospital service, when you finish school, — you leave behind you the situation where the largest proportion of your patients have some grave disorder, or at least a serious suspicion of some grave condition; and being saturated with the conviction that all illness is due to definite pathological change in some body tissure, you become sorely puzzled, and either pin the nearest possible diagnosis on the case, or conclude that there is nothing the matter — perhaps it is "just nerves."

But before you are launched out on your career and get into that bewildered state of wondering what is the matter with your patients, you will have ample opportunity to observe how *illness* and, in the absence of disease, how the *idea of illness*, alone, reacts on the adaptive mechanism of the human being. In spite of the fact that the emphasis may be on discovering what the disease process is and then on the methods of treating that particular disease, you can, if you will, study what that disease is doing to the individual who happens to have it, and see that the individual, the personality, the mind, is being affected by what is going on. Some

patients may be delirious and disoriented; but most of them will be in reasonably full possession of their mental faculties.

To these, the illness or the suspicion of illness has some significance. With most of them it means serious loss of time and money and the resultant economic difficulties for them and their families. They want to know how long they will be sick, whether or not they are going to get well, whether they are going to be handicapped. There is nearly always some degree of worry or apprehension and these are based on the primary emotion of fear. Perhaps the efficiency of the hospital organization, the nurses, the presence of doctors, the idea that something is being done to get the patient well, are enough to quiet the emotion. But not always. He wants to know something about it and he has to be reassured. If you were to become ill any day now, would you not have some feelings in regard to the matter? How would you take the enforced absence from your studies? Would you look forward with pleasure to making up the work? Perhaps you would fear being unable to continue your medical course — in any event, some emotional disturbance appears as a part of the illness and demands reassurance.

This emotional factor appears to some extent in every illness. It may be of such little moment that it disappears from the picture as the result of the feeblest quip by the doctor. But on the other hand it may be a most persistently present and troublesome feature, seriously

threatening the course of the disease. Apprehension not infrequently clouds a diagnosis by exaggerating symptoms to the point that the doctor's own suggestibility falls victim to the patient's fears. Anger at having been such a careless fool as to run his car off a thirty-foot bank can make a man restless and intractable and delay union of a fractured clavicle. You can easily see such crude results of emotional activity, but the more subtle actions on the circulation, the stomach and intestines, the endocrines are not so apparent to the eye. As you well know, these latter actions *are* there, and they are playing a rôle in the disturbed mental state, and thus affecting the illness. So some knowledge, then, of human *emotions* and how to handle them is going to be of vast help in the proper care of your patient, whether he be you yourself or someone else.

In regard to the factor of intelligence in the sick person we often find reason to be astonished. As I have said before, the intelligence modifies the emotional demands — that is, it should so act. We should do better to say that it *tends* to modify — for surely we see many an intelligent person, in the face of illness, or even the idea of illness, exhibiting very little of that quality. He may be an extremely wise banker or she may be a most efficient housewife, but when illness comes in through the door, intelligence seems to fly out of the window. Sometimes they attempt to use that intelligence in diagnosing their own case and telling

you how to treat it — a most annoying situation to a self-respecting physician! And they may know enough medicine and be so orderly and impressive in their presentation of symptoms that we lose sight of the main facts. Beware of the intelligent patient who thus misdirects his own and your mind. It is up to you to care for and satisfy that part of the patient as well as his emotions and his body. Take it for granted that practically every sick human with whom you come in contact has at least some degree of intelligence, and that the more you can get it constructively and cooperatively to work, the more glory to you and the more comfort to your patient.

The same can be said of the spiritual factor. As with the intelligence so with this, it is sometimes hard and sometimes impossible to find. But take its presence for granted also and see if you cannot get it to work as courage, hope, and acceptance. It is always a constructive help and often a mighty defence against disease.

Perhaps you cannot be expected at this stage of the game to be master of all this technique, but there is little to prevent your trying it out, and nothing to keep you from observing how your instructors use it in their contact with patients. See how some leave many of their patients wondering and unsatisfied, though mechanically and pharmacologically they may have done all that is needed. Watch others and see their patients leave them happier and satisfied. These have added that essential pat on the back or word of encouragement

that comes from the recognition of the patient as a human being.

If all of these things are true when there is actual disease present, they are many more times true where there is slight or no evidence of disease except in the mind of the patient. And remember that, when you start in practice for yourselves, this latter group is going to constitute a very large part, if not most, of your practice. Some general practitioners with rich experience state that, apart from the acute infections, at least half, and some say seventy and even eighty per cent, of the cases they see have no demonstrable organic disease. Some of the best known ophthalmologists have said that in from twenty-five to thirty-five per cent of their cases, the symptoms are exaggerated far beyond what the actual findings would warrant. In other words, we can say that there is a very distinct mental disorder complicating and maybe creating the disturbance in a large number of human beings who go to doctors for help. The great success obtained by osteopaths, chiropractors, Christian Scientists and other so-called healers shows all too well that we doctors fail frequently and miserably in this large group of cases.

I have emphasized so far the need for understanding the mind and its reactions in your patients, and have indicated that some knowledge of your own mental mechanisms would help. Psychology even more than charity should begin at home. The more you learn

about yourself, the more you will understand others. It has often been said that you cannot be a really good doctor until you have had a serious illness yourself. It is certainly true that after some such illness you can more easily put yourself in the position of a sick person and can know better what his feelings are. You cannot have every type of illness, but one good one teaches you a grest deal, and you do not have to stretch your imagination very hard to understand the rest. Most of you have had some acute illness and it has not been hard to bear. But a long-drawn-out affair or a protracted and disquieting convalescence is quite a different thing, and may be a very severe strain on the sturdiest morale. Even though you may not have experienced this, you can still extend your imagination if you have the desire and the patience to do so.

All that I have said of the human make-up applies to each one of us as well as to our patients and I wish to make one other point that is equally applicable. You have heard many times of that quality within us which enables us to accept without critical judgment some information presented for our consumption — the quality called "suggestibility." It is at the bottom of credulity and gullibility. Someone has called it the back door to the mind. It is not a bad quality when understood. We should not have been able to acquire any information had we not had at bottom the tendency to accept what was handed to us by parents, teachers, books; had we not accepted them as authorities and

swallowed what they told us, hook, bait, and sinker. Although we are supposed to get less suggestible as we gain in age and knowledge, we do not necessarily do so. Perhaps we become more discriminating in the authorities we accept, but still we remain suggestible. And particularly do we remain so in fields of knowledge about which we know little. Ask any stockbroker or banker what class is most easily lured into get-rich-quick schemes and you will find that he usually, and with good reason, takes his fling at us doctors. But even in our own field we are not infrequently led astray. As we find various forms of therapy falling short of our expectations, we turn hopefully to new drugs and new methods of treatment that may be heralded with all the art of suggestive advertising. Unless we make careful use of that best antidote for suggestibility, the scientific mental attitude, we may be led into great disappointments. No one need consider himself as entirely free from suggestibility, although many do. An active mind can give so many apparently good reasons for its position that there seems to be no possibility of suggestion having entered in, and it can fool its possessor — and perhaps its possessor may be you. But many times in illness you will have reason to suspect it, and when you recognize it and handle it correctly, you may be able to change the course of an illness.

There is probably no field so fertile for the growth of suggestibility as the field of health; and therefore no

human relationship in which it plays so big a part as the relationship between the sick person and the one to whom he may turn for help. And as you will be the person to whom many, we hope, will turn for help, it is vitally inportant that you understand as clearly as possible the mechanism of suggestion.

I have already said that we are all suggestible, that we were probably more suggestible when we were children, and I want to add that when we are ill or exhausted or in an emotional state, we are a readier prey to suggestion about health or ill health than when we are well. Dr. Thomas Salmon noted, as did others, that men brought into the front-line dressing stations soon after being wounded, blown up, or exhausted, were in such a mental state as to receive practically any suggestion of incapacity. "Why can't you move your arm?" was enough to paralyze functionally an uninjured arm until the counter suggestion was given. And it was at precisely this time that many a functional illness began. The critical judgment was in abeyance, and the fear of death or permanent handicap strong — no wonder some inadvertent and thoughtless remark by the surgeon struck deep and stayed. Of course other elements came in later to make the functional disturbance persist; but, except in cases of deliberate malingering, the persistence was due to misunderstanding and not to wilfulness or cowardice.

It is not only in war time that we see this phenomenon; we are seeing it every day in civil life, and you

will see it, and probably at some time or other be the one to activate a neurosis. Mrs. So-and-So had a small lump in her breast. When she first discovered it, she was quite naturally disturbed. Her mind was of that type which immediately jumps to the most dramatic and distressing conclusions; so the idea of cancer occurred to her with all its grave possibilities. A friend had it and there had been a recurrence and a distressing illness and death. She hurried to the surgeon and he was able to give her some comfort and reassurance and advised quite rightly immediate surgical investigation. She went to the hospital in a none too happy frame of mind, clinging to the hope the surgeon had given her that this was in all likelihood a benign growth, but of course with the fearful belief that *her* case was the exceptional one. However, she was prepared to go through with it. Various other doctors examined her and finally the interne came in to fulfil his duties. He made a careful examination and sagaciously remarked: "Well, if it *is* cancer, it is probably early enough to remove it entirely." Obviously the statement was calculated to be comforting. But that doctor had failed utterly to size up the whole situation, had probably given no thought to the woman's mental state, and never realized that his casual ill-advised remark kept her awake all night and added to the fear that was already there, so that even after the growth was proved benign by microscopic examination and her reason tried to believe it so, she continued to fear a recurrence.

One might say: "She was just a foolish scatter-brained woman. We can't waste time trying to spare the feelings of such stupid people." But what is our function as physicians — to *add* to suffering? Surely not. In our care of the patient we must do everything possible to alleviate suffering, and I repeat, the mental suffering in a very large proportion of your cases is just as great as, or greater than, the physical suffering.

In the matter of advice given to a patient, suggestion plays a large part. Remember that he has come to you because he regards you as an authority. You are a doctor, one who is learned, and supposedly able, in this problem of disease, to give advice to the ignorant. You are supposed to know a great deal. Certainly you are apt to know more about the matter in hand than does the patient. So the scene is set all ready for the creation of a belief; the mind is receptive and often eager to hear your words of wisdom. Then, if you happen to impress the patient with confidence in your ability, the matter is clinched; whatever you say goes, unless you may subsequently be proved wrong. When you have your patient's confidence, you will sometimes find to your dismay that your slightest remark carries great weight, that a jest has been taken seriously, that advice good for one situation has been applied to another, where it is *not* good. "Now look here, you are making far too much fuss about that belly of yours; forget it! It isn't a question of water on the brain with you, it is a question of stomach on the brain. Go on about your business

and every time you get a pain, thumb your nose at it!" Excellent advice when it was given after a careful examination to eliminate the possibility of a diseased condition, and an inquiry into the patient's recent experiences had revealed a habit of watching every abdominal sensation with microscopic attention. But when two years later her trusting belief, and desire to prove, that she could live up to a standard of disregard for pain which she mistakenly thought had been indicated, led her not to "fuss about her belly," she went too far and had to have prolonged treatment for a proved gastric ulcer. So you see we have to watch our step at every turn. We are not dealing with machines that do just what they ought to do under every condition; we are dealing with responsive living organisms that sometimes behave in most unexpected ways — unexpectedly generally because we have not had the wit to foresee them. The charlatan, the patent-medicine vender know all about it. They are past masters at playing on the suggestibility, the credulity of suffering humans. They use it for their own gain to spread and intensify the idea of disease and therefore suffering. You can use it to reduce, and often eradicate, suffering.

I am not advocating the value of suggestion as a sole therapeutic remedy. That system should have had its day. But I wish to point out that many a time suggestion is the real reason for astounding results credited to some inert drug, and that the physician may therefore blind himself. The scientific pharmacological labo-

ratory has done much to open our eyes in this regard and is continuously showing us that the actions claimed for many so-called specific remedies are not only false but ridiculous. And yet some of the actions claimed seem to come true. When a doctor believes implicitly that a certain preparation will be effective, he will dispense that preparation in such a convincing manner that the result may be obtained in spite of the preparation's inertness.

A man of fifty-eight with an involutional depression felt much better after the impressive administration of a mixed gland tablet, T.I.D. But the improvement did not last. Later he felt better again for a while on mineral oil.

Every new discovery in medicine is exploited by unscrupulous and unqualified persons. Probably nowhere has this been better exemplified than in the endocrine field. Soda bicarbonate or sugar of milk, given in the same dramatic style for functional symptoms, would do just as much good in many cases. Suggestion may help for a time but used in this way it soon goes wrong. Rarely is it legitimate to encourage a patient in his ardent belief in the power of medicines, and just as rarely is it legitimate to make use of suggestion in giving medicines. The more a doctor advocates medicines where he honestly knows they cannot have the effect claimed, just so much more does he encourage a false belief. True, the habit of belief, the trust, in medicines is strong within us. To take a medicine gives us the feeling that something is being

done to help our discomfort, and often we bring comfort by giving a patient a prescription. A doctor who gives medicines only when he feels honestly that they can be a specific help may drive many patients from his practice. If this is so and medicines can sometimes give comfort of mind if not specific relief, you may ask, should we not make free use of them in spite of our unbelief? Perhaps yes, when we are dealing with an intelligence of low order or are struggling against a firm conviction of faith in drugs, or if we have not enough resourcefulness to give our patient some *other* form of therapy. Please do not misunderstand me. I am not trying to relegate all use of drugs to the scrap-heap (they have a tremendous field of real usefulness), but I do urgently desire to do away, as far as possible, with the indiscriminate dispensing of useless substances which makes for a dependence on a very fallible support from without when the patient should learn to develop support within himself — a support of far greater and more permanent value. Suggestion is a double-edged tool; it cuts both ways. It all too often works to the individual's harm, but it can be made to work for his good.

I have heard an ecstatic account of the marvellous feeling of relaxation and quiet peacefulness stealing over the body with a night of perfect sleep after the administration of an hypnotic capsule; and from the same patient the story of almost immediate and miraculous relief from the acute suffering of dysmenorrhoea upon taking the prescribed medicine. In each case it was a capsule of

bicarbonate of soda. This young woman had inherited an almost impregnable belief in the necessity and efficacy of drugs for the slightest complaint. Her own multitude of experiences with fifty doctors, by actual count, had only served to strengthen this belief. She carried with her a suitcase of remedies, a list of which would fatigue as well as amuse you — each one given by her various medical advisors with due form and suggestive ceremony as absolute specifics. Some of them were products of France, some of Switzerland, others of England; coming from a foreign land and perhaps with directions in a foreign tongue each had its own very special virtue. But she was taking only five of these regularly every day — the rest for emergencies that arose with great frequency and upon all sorts of occasions. You can readily understand that this situation was an indication of a serious state of mind. The fixity of beliefs extended to other fields, the operation of her suggestibility was not confined to pharmacological actions. On winning her confidence it was fairly simple to make substitutions in the medicines, to deliberately fool her and then at the proper time with all evidence in hand, lay the cards on the table and watch the false beliefs come tumbling down like a house of cards.

That sort of thing is done often enough, but too often it is left right there. The patient feels resentful at having been tricked. But when the proper groundwork is previously laid, and the cards put on the table, your motive understood as being helpful and not as just

being funny, and most important of all, when you go on to help build a house of bricks, not cards, you have been of constructive help in the care of this patient. It must always be remembered that when you take away a support you must put some other support in its place, and this new support should be stronger and more effective than the old one. It is hardly fair to humiliate a patient and break down his good opinion of himself unless you stand ready to help him build a better opinion founded on realities rather than on falsities. You cannot help but use suggestion in building the new foundations, as you believe in them yourself and want the patient to believe in them. But where that suggestion brings about an effective confidence on the part of the patient in his own capacities and resources, you are helping to make him a more useful and constructive person, and in your care of him you are using that indispensable feature of the art you practise — understanding of his individuality and his needs.

We have heard much in recent years about *auto-suggestion*. You know without explanation what it is. But do not brand it entirely as buncombe. Coué, and many others before him, gave real help to many people by this limited method of psychotherapy. Nearly every physician, whether he knows it or not, starts up at some time or other a train of ideas in the patient's mind that works for good or harm. When we tell a patient he is going to get well, he will, if he has adopted the suggestion, use it automatically in his own way, to

suggest to himself this beneficial thought. If we lack assurance, in word or manner, most probably an apprehensive patient will seize upon it and present himself with a whole series of unpleasant and alarming ideas. Some doctors wear a funereal expression and speak in subdued and foreboding tones that become an undertaker, but do not grace the sick room. Others, though reasonably cheerful, always seem to say the wrong thing, or even the right thing but with the wrong inflection. Such simple words as "Why did you eat that?" or "Do you have pain here?" can be said in such a way that the patient wishes he had taken out more life insurance. It is needless to say that we should, just as far as possible, keep from making adverse suggestions, that we should not blame the patient for having this susceptibility, but that we ourselves should learn from the mistakes made and thus prevent any more suffering as the result of our own clumsy technique.

Reference has been made to and emphasis put upon the great extent to which the emotional factor, "nervousness," appears in illness and the necessity of appreciating this and making it of itself a definite target for your therapeutic marksmanship. It is obviously important in acute diseases, but is many a time lost sight of in the after-care and in long drawn-out or chronic cases. With reasonable reassurance most people ride through a short illness without much emotional aftermath. But it takes a sturdy and unusually well-balanced character to carry on evenly and undisturbed,

when the convalescence is slow or if the condition becomes chronic. Here we can see that over-specialization in medicine may have proceeded at the expense of the best interests of the patient. The splendid "old-time general practitioner" was one who knew how to give the right care all through the disease, be it acute or chronic. He may have used medicines and measures of which we no longer approve, but he *treated* his patient body and soul, and helped him to make the difficult adaptation, when things began to drag along. Although the type of "family practitioner" is slowly disappearing, the same characteristics that went to make him what he was are still present in human nature, and still exhibit themselves in many a follower of Aesculapius.

But the so-called specialist is too apt to confine himself too closely to one organ or disease or even one aspect of one disease and to neglect almost entirely the creature who is carrying around the disease and who is suffering from it. He is indispensable when he is needed, and that is often enough. It is of tremendous value to have his wise and well-balanced opinion and counsel. He not infrequently helps to tip the scales in the right direction. But he is apt to lose interest when his particular function is fulfilled, when the aspect of the disease that interests him most changes. He is not the only one who loses interest, however. And this is a very important point — you cannot hope to give adequate care unless you retain your *interest*, and it may be necessary to *force* that interest, in your patient as well

as his disease, throughout its entire course, no matter how long. The surgeon, perhaps even more than the internist, comes in for a great deal of abuse in this respect. For some reason he has acquired the reputation of leaving his patient rather severely alone after he has operated and danger of death disappears. But whether we be absorbed in surgery, or any of the other branches of medicine, the fact should not be lost sight of, that the life that has been saved and must be lived, is important — even more so than the saving of it. Is it not a very real part of the physician's function in his care of the patient to see to it that the life which has been helped through disease and maybe saved from death, is not left with an unnecessary invalidism?

We doctors, who do our best to prevent and cure illness, can and do actually cause illness; not physical illness, to be sure, but mental illness. A certain sensitive person, who overemphasizes his physical aches and pains and tends to fix his attention on any disordered bodily organ (thereby adding a further disorder in function), came through an operation on a probably fictitious chronic appendix beautifully, but was left with a beautiful gastro-intestinal neurosis. Another person had symptoms of gastric ulcer warranting dietary treatment, which successfully caused the ulcer symptoms to disappear but left equally important and more persistent symptoms of a gastric neurosis. In each case the life was made miserable and the misery extended to others by the dietary demands and over-

protective measures, supposed to be necessary. When you start out in your own practice, these cases of failure, on the part of other physicians, to recognize the neurotic, the mental condition, or if recognized, the failure to understand, to sympathize, to treat it—these cases will take the nice fresh bloom off your new office furniture. They are the ones that come flying to the new doctor as the bees crowd round the first flower that opens in spring. They have tried out each new doctor in turn, and for a while, perhaps, have benefited. But each time they fall back again into the old aches and pains and wearily they recite the same old story of their symptoms. Had their condition been understood early enough in the game, many of them could have been prevented from forming habits of ill health. In the hospital wards you find a certain proportion of these cases. They give students and internes a good deal of practice in history taking, physical examination and laboratory work and constitute a very appreciable proportion of the "chronic" appendices of the surgical wards and the "gastric, for study" cases of medical wards. But you see more of them in the medical outpatient departments. You know how they are shunted off from one department on to another, how tiresome they are and therefore how little constructive interest is taken in them. At one time if their background had been understood, if the home conditions had been known, and the symptoms of disordered function had been recognized as being due to worry over a drunken

husband, or poverty or what not, they would have been treated more appropriately. The Social Service worker has become an indispensable factor in arriving at a diagnosis in these cases when we ourselves cannot get at the environmental situation. Her evidence has become as necessary as laboratory reports and special consultations.

You have, then, plenty of material in this functional type of disorder and plenty of opportunity to familiarize yourself with it. It will help you to do so. You can be far more effective when you realize with what you are dealing than when you are trying to treat some condition that is not there. In that practice which you are going to build up you will have need of recognizing just how much nervous elements are complicating or causing illness; it will be valuable to the patient and to you to know how to treat them.

There is great prejudice against being thought "nervous," against having some disturbed condition for which no objective physical explanation can be found; a prejudice not only among laymen but among members of our own profession; a prejudice founded in some on honest, but in others on wilful, ignorance. A conscientious, honest doctor had long treated a certain patient for nausea and other suggestive abdominal symptoms, "palpitation" of the heart, strange feelings of giddiness, almost to the point of syncope, a great sense of fatigue after the slightest effort, and a loss of thirty pounds in six months. She herself was convinced

that she had at least one of several terrible diseases; her physician was equally convinced. But numerous examinations by competent and incompetent consultants, and every established test known to medical science proved negative; the accumulated mass of evidence pointed fatefully toward the fact that these symptoms were of a functional nature. The patient had not wanted this to be so, nor had the doctor. The husband would say "I told you so!" After the results of the last test were in and the last available consultant had given his opinion, the patient waited apprehensively for the verdict. With a long face and the air of a defeated man her doctor came to the bedside of his sick patient. "Tell me the worst, Doctor Muffit, I might as well know," and the doctor in his acute mental distress so far lost his self-command that he answered, "It *is* the worst, we cannot find *anything* the matter with you, we will have to admit that it is a neurosis; I had wanted anything but that." Figuratively the death warrant had been sealed. Why? Primarily because of the physician's inexcusable ignorance and prejudice which had added to the patient's more excusable prejudice and ignorance.

A boy who failed at mathematics in prep school was forced by stupid though well-intentioned teachers and a dominating older brother to believe that he was rather mentally deficient. In spite of other abilities he developed strong ideas of inadequacy so that he could not conform to the usual social and scholastic routines.

He had acquired by contagion the belief that there was only one right way to live, only one right way of progress. Because apparently he could not fit into that conception, he knew there was something wrong with him. It was a difficult problem to show him that there is probably no one right way in anything, but many right ways, and then finally to find a way of life that was right for his particular needs and still sufficiently within the conventional bounds of civilized society for him to lead a reasonably happy and successful life. A potentially useful and happy existence had almost been ruined through ignorance, through blunders.

Another Doctor Muffit hesitated for months before turning his patient over to necessary treatment for a long-standing neurosis, fearing that she would consider this treatment as leaving her with what he called a "social stigma." Other like-minded doctors when puzzled by the lack of positive physical findings have the attitude of one of the "Two Black Crows" when he said, "Why bring that up?"

This attitude toward the neuroses that exist by themselves, or as complications of some disease, is founded on the erroneous belief that only the unfit, the weaklings, the quitters have functional nervous disorders. Such is far from the case. True you may see this type of individual suffering from a neurosis just as you see him suffering from any other ill that the human being is heir to, and in some cases his inadequacy or his lack of moral stamina

may be a direct factor in the etiology and a barrier to recovery. But because we see a weakling suffering from a certain illness we should not fall into the error of thinking that everyone with that kind of illness is a weakling.

The higher as well as the lower types of humans because of ignorance as to how best to manage themselves can suffer from the neuroses or complicate an illness with over-emotionalism. The neuroses are no respecters of race, religion, social position or bank account. They are by no means confined to any stratum of society; the poor can and do have them as well as those who are better off. I wish to reëmphasize this point so that you can "harvest the present" by realizing the great opportunity that you have now in each of your clinical courses, so that you can save yourself and your patient from serious blunders.

There is no other profession or occupation where the relation between human beings can be as thoroughly close and as helpful as that between doctor and patient. To make that relation work for the greatest good we must always remember the nature of the material with which and the aims toward which we are working. No one is blind enough to go into medicine to get rich. The origin of the Medical Profession is, as Osler said, founded in that age-old desire of man to help his suffering brethren. Some eighteen hundred years ago Marcus Aurelius wrote "It is man's special gift to love even those who fall into blunders; it operates as soon

as it suggests, that men are your brothers." "Men exist for one another. Teach them then or bear with them." *There* is a philosophy for us that embraces tolerance, sympathy, patience and understanding. In the care of our patients are there any better precepts?

VII

The Care of the Aged

By Alfred Worcester, M.D.

IN contrasting the abundance of pediatricians with the lack of specialists in geriatrics, it has been suggested as a reason for such partiality that, whatever the doctor does for children, they generally recover, whereas, whatever is done for the aged, most of them eventually succumb. I venture to add, two other possible reasons for the neglect of senescence as a specialty. In the first place, the field is limited. Only a few of those born into this world survive the vicissitudes of infancy, childhood, and maturity. And this, by the way, is most fortunate; for, otherwise, if all lived to be old and the burden of caring for them in their increasing helplessness were thus added to the present burden of caring for the helpless young, this would be a much harder world for those in their prime. And yet, even heaven, were it only a harbor of refuge for the superannuated, would offer no alternative attractions.

Another reason for ignoring old age as a specialty lies in the increasing inability of the aged to travel to the doctors' offices or to find hospital accommodation. Is it then any wonder that the care of the aged still

devolves upon the general practitioner! But this freedom from competition is not the advantage to him that it might seem. For the advance of medical science, upon which the art of practice depends, is now furthered only by the discoveries of the specialists. Dazzled by the brilliancy of these, general practitioners have ceased communicating to the profession even the results of their experience. Consequently, in their particular fields neither medical science nor the art of practice advances. The care of the aged is of course just as much the family physician's business as the care of those younger. But for the medical student who wants to prepare for the care of the whole range of human lives, how different are his opportunities!

Although some of us can remember the earliest pediatricians, what an immense advance already has been made in their specialty, and how voluminous its literature has become! On the other hand, who ever hears of improved methods of caring for the aged? There is, however, one magnificent exception which will at once occur to you. The surgical removal of sex organs, that not only are no longer of any use but are often obstructive and always prone to malignancy, is one of the greatest boons our profession has ever brought to humanity. In the prevention of suffering, prostatectomy, for instance, is second only to the discovery of anaesthetics.

As for the medical literature on the subject of senescence, perhaps the less said about it the better.

The few volumes that can be found in our great libraries are, for the most part, only dreary repetitions of each other. One finds in them little more than compendiums of all known diseases, with some small discussion of their modifications as caused by old age. One of these treatises, much esteemed by later authors, if we may judge by their liberal quotations from it, was given by the Harvard Medical School in 1885 to the Boston Medical Library, where it is still, so far as I can find, the only copy hereabouts. Its uncut leaves, as I found them last summer, seemed to offer silent testimony to the local lack of interest in senescence.

The treatment recommended in these books for the diseases occurring in old age varies, of course, with the fashions of their different periods, as well as with the fads of their authors. But in tracing this changing therapy, from the days of phlebotomy and shotgun prescriptions down to these days of therapeutic nihilism, it may be questioned if there might not have been some value in the treatments employed in bygone years. And this question becomes more pertinent if we remember that the relief and comfort of our aged patients should be our main aim, rather than the prolongation of their lives. But this is hardly a true distinction; for the relief and comfort given to an aged patient often effects the prolongation of life, if only by restoring the willingness to live.

A discouraging feature in these treatises on senescence is just this emphasis on possible ways and means of

escaping old age. But in the dim light of past centuries the search for an *elixir vitae* somehow does not seem so ignoble as gonad implantations for rejuvenescence seem in the light of our present knowledge of biology. The acceptance of ageing as a perfectly natural process is the only proper basis for our study of the ideal care of the aged.

Anatomical changes that are inevitable are not pathological. Nevertheless, these normal structural changes that evidence old age occasion functional changes that require a change of régime. Just as structural change in the growing child, with consequent change of functions, requires a corresponding change of régime, so, as the helplessness of age increases, a regressive régime is indicated. And, be it noted, if medical supervision is needed in the care of the child's development, it is needed even more in the care of the regressions in second childhood, where besides the ignorance and prejudices of the family there is also the patient's own to contend with.

I do not know that there are any diseases peculiar to old age, or any from which the aged are exempt. The infrequency of the common diseases of childhood can be easily explained by the immunity acquired in having had them. But the relative frequency of diseases at different ages is of small consequence. That, however, cannot be said of the various modifications of disease observable in the aged. This is a subject that needs far more attention than it has yet received. My present

purpose, however, is rather to consider the personal care of the aged, whatever may be the natural or accidental causes of their helplessness.

In my forty odd years of general practice I have had the privilege of taking care of many very old people. One of them, Mrs. Julie Boudrot, lived till within a few weeks of one hundred and eleven years. As such an extraordinary report needs all possible verification, I make no apology for presenting these data. When she reached her centennial she asserted that she was born in Arichat, C.B., October 28, 1806, and that she was baptized in the schoolhouse there before the church was built in which she was married when she was twenty-five. Her priest, Rev. Fr. La Croix of St. Joseph's parish, Waltham, wrote to the priest in Arichat for confirmation of the story, and was duly informed that before the church was built, early in the last century, the schoolhouse was so used, and that, while the parish records of 100 years back had been lost by fire, the record of Mrs. Boudrot's marriage in 1831 was intact, in which her age was given as twenty-five. Her eldest child, who is still living, claimed to be in her seventy-fifth year at the time of her mother's centennial. Mrs. Boudrot died August 15, 1917. Her coffin plate, now in possession of her granddaughter, states her age as 110 years, 9 months, 17 days. A year before she died she walked half a mile to and from church every Sunday. Her body was shrunken but not much bent. Only her withered and wrinkled countenance bespoke her great

age. Until the last few months of her life she was busy with housework. She had lost neither sight nor hearing, and her mentality was not dulled even the day before she died. Her only idiosyncrasies were constant demands for candy and aversion for drinking water.[1]

Besides this woman I have known five other women and one man in my neighborhood who lived more than a century. I cannot claim they were my patients, although one of these women, when ninety-nine years old, so far recovered under my care from a fractured hip that she was afterwards up and about. It is perhaps needless to state that in this case the treatment was expectant.

With such experience, and with the increasing reports of similar cases of great age, it is natural enough that I should believe normal, human life exceeds the extreme limit of four score years, as given by the Psalmist. No more can I accept King David's dictum that after three score years and ten a man's life is but labor and sorrow. Many of us know better!

In normal senescence labor naturally becomes less fruitful, but life, while lacking the ecstasies of springtime, yet has in it the peaceful warmth of autumn; and nearer its normal end it should be expected to have, not the winter of discontent, but rather the lovely haze of Indian summer.

To guard and promote such normal senescence I hold to be one of the physician's great privileges. Just

[1] Part of this story of her life was published in the Boston *Post*, October 29, 1916.

as his heart may well rejoice in helping babies to be born, so too in the tender care of the aged he can find deep satisfaction. But this highest of all rewards for the doctor comes to him only by personal devotion to his patients.

Normal babies perhaps can be cared for by the wholesale: not so, old men and women; they need individual attention; no two cases are alike. Moreover, the treatment suitable for younger patients becomes progressively unsuitable for the aged. Their comfort and not their impossible rejuvenation should be the physician's aim.

Let me illustrate this by one of my many mistakes. In the first year of my practice I undertook the case of a rich old man, misshapen by *arthritis deformans*. I made notes of his history, I examined his body and his excretions. And then I ordered for him the treatment that in those years was according to Hoyle. As his pulse was irregular, I cut off his tobacco. I did not allow even the meats that he depended upon. And in place of his gin I gave him nauseous draughts of salicylates. When a few days afterwards he sent me the complaint that he must have relief I cruelly answered that I should make my visits only as often as I thought necessary, and that either the treatment I had ordered was to be continued or another physician could be summoned. The old man managed to live through the winter. Before he died he gave me this lesson. He had called for my help, he said, because of his suffering,

not because he expected or even wanted to be cured. In spite of his confession of lifelong dependence upon alcohol I had taken that away, and also even the comfort of his pipe. I had changed his diet from what he liked to what he loathed. And, worst of all, when he wanted the encouragement of frequent visits, which I knew he was well able to pay for, I had refused him even that boon. He was too proud, he said, not to obey his physician's orders, but he wanted me to know how much more miserable I had made the last year of his life. My only atonement has been in never again making such an egregious blunder. And I report it in the hope that you, my younger brothers, will never make the mistake of treating your aged patients as if their rejuvenation were possible.

In the care of the aged the young physician will often be humiliated to find how useless is much of what he has learned of the nature and treatment of diseases in the clinics where the aged are so seldom seen. May I report to you my first lesson of this kind? I was given the care of a dear old lady in her ninetieth year. She was the widow of the physician who helped my mother when I was born, and I was just assuming the practice of her only son, whose failing lungs were driving him to Colorado. The impending separation, which both mother and son felt would be final, was too much for her. She had given out completely. Too weak to leave her bed, unable to take half enough nourishment (if calories were to be counted, as in point of fact they

never should be in such cases), she lay there patiently expecting and almost hoping for the end. Her son, who was one of the wisest physicians I have ever known, told me that he had never examined either his mother's body or her excretions, and that, consequently, he knew nothing and wanted to know nothing about her internal organs. He would be glad, he said, if I should continue to think of her simply as his mother rather than merely as a patient. I could not understand him then as I do now. But it was easy to follow his wishes, for she was as ready to think and talk of other interests as she was averse either to think or to talk about herself. She was eager to hear what I was doing for the patients whom through her husband and son she had known all about in the past. She enjoyed gossip, or rather, as she put it, she was interested in the biography of the living. For such a patient it is easy to make full use of diversion, which, after all, is the best remedy any of us ever can provide for our patients. Under this treatment it was not long before she was taking more nourishment and sitting up a little of each day; and then, to her surprise as well as to mine, she came downstairs, went out of doors, and was herself again. Three years afterwards her strength began to fail. It became more comfortable for her not to leave her bed, and to take no more nourishment than would keep a bird alive. She craved quiet, and so we did not disturb her. When she roused, her senses were still acute and her wonderful mentality unimpaired. So it was until an

hour or two before her perfectly peaceful death, on her ninety-second birthday. I do not know what especial failure caused her death. I only know that her radial pulse for some weeks was growing weaker.

Of course, this was in every way an unusual case, and I report it only as an offset to the modern conception that the physician's main duty is to discover in every case the pathology involved. In the care of the aged this search is by no means always necessary, and less often is it of any use. Symptomatic and sympathetic rather than theoretic treatment is generally all that is needed. But I am well aware that aged patients now-a-days and their families often require of their physicians thorough pathological investigation. They want to know just what tissues and organs are affected and the names of the invading germs. The misery of such knowledge is that it is apt to centralize the patient's attention upon his woes, and also at the same time to divert the physician's attention from the vastly more important objective of his patient's personality. Often, as our Dr. Holmes so well said, it is no kindness for science to reveal what Nature is kindly concealing. For example, when the physician finds in his aged patient some internal tumor, of whose presence the patient is unaware, it is well for him, remembering how common in the aged cancerous tumors are and also how much less malignant than in earlier years, not to mention his discovery. The patient will not live so long or so happily if told of it.

Perhaps it is impossible, certainly it is very difficult to decide between what is normal and what is abnormal in senescent anatomy. The vascular changes, for instance, present this puzzle. Premature rigidity of the arteries can be considered only as a product of disease — it is unnatural. But in the aged how normal such a condition seems! Indeed, we can find no better explanation of the perfectly normal ageing of the body than the consequent diminishing supply of nutriment to the tissues and the diminishing removal of waste from them.

Fortunately, this difficulty of distinguishing between normal and abnormal conditions, while obscuring the nature of an aged patient's disease, is of only small importance in deciding upon the proper treatment. For instance, in cases of pneumonia it matters little whether it be broncho or lobar, the treatment in any case will be the same; and disturbance by repeated percussion and auscultation, to say nothing of blood examinations, is worse than useless. So, too, in cases of uraemia the treatment is the same, whatever its cause; and in so asserting I intentionally disregard the advice of those who would lumbar puncture uraemic saints for a Wassermann.

Their minor ailments often seem to the aged more important, and to the physician such ailments often seem more intractable, than their graver sicknesses. Many of them are only the natural consequences of hygienic violations. I shall not attempt even their enumeration;

for I need every minute of my time to emphasize the greater importance of befriending our aged patients while striving to relieve them of their miseries.

As Sir William Temple said nearly three centuries ago, "In all diseases of body or mind, it is happy to have an able physician for a friend, or a discreet friend for a physician; which is so great a blessing that the wise man will have it proceed only from God, where he says: 'A faithful friend is the medicine of life, and he that fears the Lord shall find him.'"

In establishing this ideal relationship with his aged patient the physician needs an inexhaustible stock of patience. For the aged are often garrulous, and their complaints, so grievous to themselves, often seem trivial to others. But their confidence is childlike, and so, too, is their intuitive recognition of true friendship. Their complaints not seldom are magnified by their hunger for sympathy. The physician's largest chance of helping them is in decentralizing their attention from their woes, in infusing new hopes, in inducing composure and tranquillity of mind. If he gives some simple medicines, which, even if unnecessary, are neither nauseous nor otherwise harmful, or if instead he leaves only particular directions for the regimen to be followed, the medicines or the orders may be of great value to the patients as frequent reminders of his helpful efforts.

Curiously enough the cling to life generally increases with age. It is not safe to accept at face value an old

woman's insistence that she longs for release from this world. I remember one who, after such a declaration, was horrified by the suggestion that the water supplied by the city was fit to use with her toothbrush. "Just think of the germs in it," she said.

As a part of this clinging to life, long after it would seem to contain no compensations, there is often the hallucination that the end is near. Many take to their beds too soon and so shorten their lives. Nor is it any use to argue with them on the subject. They can be encouraged only by indirection. I once succeeded in so doing by having the old man's clothes hung where he could see them. The sight of his trousers served as a magic tonic, where champagne and strychnine before had utterly failed.

However hard it may be to get the aged patient up out of bed, that is often the only way of saving him; and often the only way of doing it is for the doctor himself to carry the patient as he would a child from the bed to a chair by the open window. Well it is for doctors and nurses that the aged so seldom weigh much! In this kind of service we have a perfect illustration of the personal care that should be given, which the medical profession has lost much in surrendering to nurses. The reluctance of the patient to leave his bed probably is due to his fear of falling or even of dying. And, in fact, there is danger at least of syncope when the body long accustomed to the horizontal is uprighted. Naturally enough the timid patient will do for his doctor what he will do for none other.

More warmth, more rest, less strenuous work and less food are the four main hygienic requirements of senescence.

It is in the matter of diet that the doctor will have his greatest difficulty. In no other respect is the personal equation of more consequence. For while it is perilous to make radical changes in the habits of the aged, yet it is imperative for their welfare that they should ingest only a decreasing fraction of what in their active years may have been more or less rightly considered their proper quantity of nutriment. The shedding of teeth may be, as Sir Henry Holland insisted, the natural safeguard for the aged against overeating. If so, this provision is largely offset both by the dentist and the *chef de cuisine*. Artificial teeth and culinary triumphs are the disguised enemies of a healthy old age. As only those whose diet is very spare live to extreme old age, we might well suspect that many of the ills, as well as the deaths, of the aged are caused by overeating. At any rate, anorexia deserves more respect than generally it receives. A sick animal cannot be forced to eat, or to drink anything but water. And if this be one of Nature's cures, as certainly it is, what chance has the sick old man or woman against the customary urging of nurses, family and friends! There is no heed paid to the patient's plea of entire loss of appetite: that only stimulates the cook and also the neighbors to offer more tempting dishes. The physician, wise enough in such a case to take Nature's cue,

will often save the patient. Fasting is a wonderfully effective remedy for many an ill turn. And if only it be kept in mind that what is in the alimentary canal is not in the body, except of course as it is geometrically inside, then the need becomes plain of guarding the less resistant intestinal lining of the aged from all hostile invasion. Their weakened musculature favors intestinal stasis both by the consequent general inactivity of the body and by feebler peristalsis. The necessary precautions are obvious — first, a non-putrefactive diet that can be easily digested and absorbed, and, second, thorough catharsis and flushing of the bowel at the least sign of toxaemia, to be followed by complete rest of the digestive apparatus until the anorexia or the false hunger of indigestion is replaced by what is real.

Especially often, however, in the care of the digestive functions of the aged it will be found safer to allow what the patient likes and what has been his customary diet, than to change it for what theoretically would seem much safer. The enfeebled digestive glands need every possible encouragement.

Though milk generally is the best food for the aged, as it is for the young, it is not safe to disregard the occasional dislike of it. Restriction in the amount of nourishment brought to the bedside is often more important than its quality. On the other hand, cases are not infrequent where the patient only with great difficulty can be induced to take enough food of any kind. Such cases offer fine opportunity for the study of idio-

syncrasies. Sometimes by questioning the patient about his childhood the doctor can find him really hungry for some old-fashioned food, — for an apple dumpling, a hot doughnut, or a pie such as his mother used to make, — when seemingly absolutely unable to swallow beef tea or malted milk.

Not only in the matter of diet is it serviceable to lead the aged patient's thoughts backwards to earlier years. The keener memory for childhood's happier circumstances than for the perplexities of maturity is one of Nature's great kindnesses to the aged, and her gracious lead it is always wise to follow. Inasmuch as the happiness possible in old age is of more consequence than mere prolongation of life, it behooves us to employ every means of furthering it. As Oliver Wendell Holmes put it "While we've youth in our hearts we can never grow old." Association with the young is therefore the best antidote to burdensome ageing. That is why the old grandfather by the fireside with children playing about is so much happier than he could be in an old men's home, however luxurious, where the miseries of the inmates are accentuated as they are exchanged by conscious or unconscious suggestion. And this is why the doctor, after first attentively listening to the whole category of his aged patient's woes, should not allow if he can help it any repetition of the story, for by each recital the woes increase or at any rate become more fixed in the patient's consciousness. But to take the burden from the patient's back the doc-

tor must shoulder it: he must remember even its least details. There is no other way of winning the patient's absolute confidence. If notes are needed they must neither be taken nor referred to in the patient's presence, as that only emphasizes what ought to be minimized in the patient's estimation.

The lack of *joie de vivre* in the aged makes them careless of their personal appearance, and conversely any aid in that direction favors their happiness. The loss of personal vanity is no small matter, and a better tonic would be hard to find than encouragement of it. The physician who notices any sprucing up of his aged patient, if only a pretty ribbon or a bit of old lace, makes a large contribution to her happiness. And it is often surprisingly helpful in the banishment of their discouragement and despondency to relieve the aged of any of their personal disagreeablenesses, of which they very likely are morbidly conscious. Success in this sort of service may be won by unremitting personal care. And while this of course is the especial business of the nurses, it nevertheless is for the doctor to require. The sum and substance of the physician's duty in caring for his aged patients is to make sure that they receive all the attention that loving friends if present could render.

The aged, as we must never forget, are always lonesome. They have outlived the preceding and very likely also their own generation; or, if any survive, only by extra good fortune can there be any more meetings. Their family separations too often have caused the ad-

ditional loss of their old homes and former neighbors.[1] To the ways and manners of the present they are not accustomed. They belong to the unforgiving past. They are as strangers in the land. Like orphaned children they long for loving kindness, such as they have lost; but, without the appealing attractiveness of youth, the aged seldom win new friends. Yet, in every community there are those who want to give, and for their own sakes need to give, loving service. And one of the best chances the physician can ever find for neighborhood bettering is in bringing together those who need and those who can give loving friendship.

As adolescence is a better term than puerility for the stage of youth, so senescence sounds better than senility for the latest stage of life. The words senile and senility, which like puerile and puerility seem disparaging, may well be reserved to describe deteriorations, which even if common should nevertheless be regarded only as complications of old age. Among these misfortunes by far the greatest is mental deterioration. However weakened the body may be, however dulled the hearing and dimmed the sight, so long as the mentality is not inpaired life is precious. When that fails the possession of all else seems only a mockery.

[1] "Wise it was of the Emperor Vespasian in his old age not to alter his father's house, being but a mean building, because the old house did put him in remembrance of his childhood: and besides on festival days he would drink in a silver-tipped wooden cup which was his grandmother's." Quoted from Ficinus by Francis Bacon in "The History of Life and Death."

Like many other common burdens of humanity that are accepted as inevitable, senile dementia receives too little attention from the medical profession. Back in my student days the prevalence of *phthisis pulmonalis* was also accepted as a matter of course. There were, it is true, "Homes for Consumptives" — to die in, just as now there are asylums for aged dements. But nothing was ever heard of the possible cure or even of the possible prevention and amelioration of tuberculosis until Dr. V. Y. Bowditch told us what Dettweiler was doing in Germany. And now if any one objects to my parallel on the ground that, while the etiology of tuberculosis has been discovered, there is no chance whatever of a like discovery in the case of dementia, let me remind him that the modern treatment of the tuberculous, which is one of the most beneficent advances in the practice of medicine, antedates by several years Koch's discovery. Moreover, if I may add my own opinion, this advance was retarded rather than furthered by the attention paid to the tubercle bacillus. I trust you well allow this digression to serve as an illustration of the folly of believing any disease to be incapable of amelioration. And I want also to point out that the advance of the practice of medicine depends upon thinking of the patient as well as of his disease. These principles seem of greater importance in the care of the aged, whose various deteriorations are so involved with their normal retrogressions that despair of their prevention or cure easily engenders professional neglect. This is especially

true in cases of dementia, where the difference between proper care and neglect of the patient becomes glaring. I need not remind you of the exceedingly disagreeable conditions where the demented patient is neglected or given only half-hearted care. Such conditions are too common not to be well known. But some of you may not have seen cases where the patient from the beginning of failing mentality has had perfect care, and where even to the final stage of complete dementia the conditions have been kept as free as in helpless babyhood from all that is offensive. In fact, the care of the demented patient in the later stages is as much easier than it is at first, as the care of the newborn is easier than it is of children older but not yet amenable to reason.

By proper care of the aged the onset of dementia can be postponed and its progress retarded; compensations for the successive disabilities as they occur can be provided, the patient's discomforts and sufferings can be relieved or at least ameliorated. Although life can thus be prolonged even after absolute helplessness ensues, I cannot adduce that as an incentive. Nevertheless, it is not for the doctor to decide that the life of his patient is no longer worth while, and, even if such be his opinion, that is no excuse for any lessening of attention to his patient's needs. Indeed, so far as is possible these needs should be anticipated. For example, no aged patient, however demented, should be allowed to suffer from an overdistended bladder or from fecal impactions in the rectum. No such patient

should ever be either under- or overfed, or, what is worse, allowed to thirst. Decubitus may not always be preventable, any more than other forms of senile gangrene, but where due to the neglect of attendants, their punishment fits the crime.

In the early stages occasional periods of failing mentality often have temporary causes, such as the fever of common colds, the toxaemia of indigestion, or the uraemia from kidney congestion. Or the attacks of mental confusion may be only the result of fatigue. In such cases the favorable response to relief measures is often astonishing. But it is not my purpose to catalogue the many common afflictions of the demented or to discuss either their prevention or their cure. Let me rather emphasize the need of meticulous care in all such cases.

Any lack of kind care of those whose mentality is failing is likely to have more disastrous results than the mere shortening of their lives. Such patients are more than normally sensitive to ridicule, disrespect and neglect. They are also more appreciative of affection and devotion. Their emotions are not only more easily displayed; they are also more easily aroused. As Carlyle wrote of his mother when nearly eighty: "It is beautiful to see how, in the gradual decay of all other strength, the strength of her heart and affections still survives — as it were, fresher than ever — *the soul of life refuses to grow old with the body of life.*" Evidently she was kindly cared for. And as evidently many of the

distressing changes of character, too often met with in the aged, are the direct results of insufficient or improper care.

If, as is commonly stated, failure to remember the names of persons we know is an early symptom of dementia, well, all I can say is that some of us have had it for a long while. For my part I like the German fashion where each in meeting pronounces his own name instead of the other's; and I prefer to consider the ability to remember folks' names as a most unusual gift from the gods. But, however that may be, the memory generally is the first function of the mind to fail with ageing, just as it is often the first and only symptom of brain fag. Whatever its cause, it must be seriously considered. Every effort must be made to relieve the memory of all unnecessary strain. If never before, certainly then system and order must replace confusion. A place must be provided for all the patient's belongings and everything kept in its place. Generally, it will be found that at different times in the day the patient's memory is better than at others, and also for shorter than for longer periods. Although frequent rests are therefore advisable, it is a great mistake to discontinue all mental exercise. The brain wilts as well as muscle from inaction. All simple enjoyments that divert without unduly wearying are helpful. But the greatest help comes from providing some occupation that will at least seem to the patient to be useful. For those who have led busy lives there is no heavier burden in their old age than having

nothing to do. There is far greater efficacy in occupational therapy than has yet been generally recognized in this country. I wish you all might have seen, as I have, the perfectly happy, industrious patients in the German Homes for the Aged. I remember an old deaconess, who was one of Fliedner's earliest nurses, as she sat under an appletree in the garden at Kaiserswerth, busy counting the linen as it came from the laundry. A young deaconess behind her who was keeping tabs said, "Oh no, she no longer can count straight, but she doesn't know it." And at Bielefeld I once saw a blind old woman perfectly happy in winding balls of ravelled yarn. She too was being helped by a young nurse. In both of these cases their dementia was being retarded and their days made happy by wise and kind treatment.

Patients, however dull and forgetful betimes, generally brace up for their doctors' visits, sometimes to the surprise and vexation of their families who previously failed to elicit any response. Here we have an indication of the physician's possible service. He seems to have later chances than others have to acquire the confidence and friendship of his ageing patient. This is what he should strive to win, for upon his success his usefulness will largely depend as heavy clouds still further obscure the patient's mentality.

In order to gain and keep the confidence of patients whose mentality is failing, there is one cardinal principle that must never be forgotten: never under any circumstances whatsoever must the doctor give even tacit

assent to their delusions. Often it is far easier to do so — to humor the patient's assumption of another name or character, or to accept the patient's insistence that the doctor is some one else, or to agree with the patient that the food brought is unfit or the attendants hostile. For the moment the patient is pleased and satisfied. But underneath the delusion there is often a glimmering consciousness still able to recognize the truth, and the doctor's assent to the delusion either fixes it or convinces the patient of the doctor's unreliability. In either case the doctor has lost his chance, perhaps forever, of retarding the progress of his patient's dementia and of retaining his patient's confidence.

No one would ever think it either wise or right to deceive a child. No more is it ever right or wise treatment of the childish aged to deceive them.

Obedience to this principle by no means involves constant effort to correct the patient's delusions. Silence is often more expressive of dissent and more potent than argument.

An old man's apparent deafness is often only his lack of attention. Long after general conversation is to him only an annoying buzz he can hear what is distinctly spoken to him in simple sentences. Disregard of this hurries many an old man into dementia. Treated as if he knew nothing he acts accordingly. So do we all act more or less, and generally more, in accordance with what is expected of us. By insisting upon continuance of the respectful treatment that would naturally be

shown to them in their prime the physician can retard the progress of his patient's dementia.

In the past I have maintained that a young woman's fitness for the nurse's calling can be determined by the reaction of babies to her care of them. In like manner I maintain that a young physician's fitness can be gauged by the reaction of his aged patients as it is evoked in his care of them. No surer measure can be found of his tact and courtesy, of his sympathy and devotion. These are the indispensable qualifications of the physician. Some seem to have them as natural characteristics; but what such fortunate ones really have is rather the facility of expression, and this facility of bringing one's kind feelings into action can be acquired by practice.

No better field for such practice can be found than in the care of the aged. In such service one's kindest motives if given affectionate expression are in no danger of being misinterpreted. Nor is there then any need of prudence in the full employment of one's heart.

In pleading for your personal devotion in the care of the aged I am thus pleading also for your own best development, for your excellence in the art of medical practice. God grant that in coming years your aged patients shall have every possible comfort and that you yourselves shall become more and more worthy of our high calling!

VIII

The Care of the Dying

By Alfred Worcester, M.D.

WHILE the main object of medical practice is the preservation of life, it for long has been held to be also the physician's duty to make as easy as possible his patient's death. Francis Bacon, in differentiating the promotion of physical euthanasia from the spiritual consolation of the dying, insisted that physicians should learn and diligently practise this art.[1] Some of England's great physicians, following this lead, have contributed their reflections, and in a few instances have given valuable advice, upon the treatment of the dying. And yet surprisingly little seems to have been written on this subject.

Inasmuch as all of our patients, as well as we ourselves, must die sooner or later, we might naturally suppose that the care of the dying would receive more attention. In the onward progress of medical science it appears to have been sidetracked. Those who are interested only in the diseases of their patients find little that is noteworthy in their dying beyond the mere fact of fatality and the possible opportunity of verifying their diagnoses. So long as there is the slightest chance

[1] Verulamus, *De Augmentis Scientiarum*, Lib. IV, Cap. 2.

of their patients' recovery the work of such practitioners is admirable. Their successes are often marvellous. But when the modern doctor knows that for his patients there is no possible escape from death's near approach, then far too often either he continues the treatment that would be appropriate were there any chance of resuscitation or even of delaying the fatal issue, or he surrenders the care of his dying patients to the nurses. Perhaps the former procedure is the less reprehensible; for the patient may be more or less oblivious of such needless disturbance, and the family, ignorant of its utter uselessness, may find some comfort in the false hopes thus engendered. Moreover, for such malpractice there is the slim excuse that while there's life there's hope and also that no human judgment is infallible.

As hardly needs be said, it often is impossible for even the most experienced to decide just when the act of dying begins. In point of fact we are always dying; and, whatever age is attained, death finally triumphs in multifarious ways. The history of the patient as well as his disease may help us in differentiating the approach of death from similar states of collapse where restoration is possible. Thūs the injury already suffered, whether by accident or disease, may preclude life's continuance, or the agony so caused may plainly have exhausted the patient's endurance. Age is also an important factor. Extreme old age is the only natural cause of death, and natural death is merely falling asleep. This crowning mercy, however, is vouchsafed to few. Infants and

young children generally die very easily; their hold on life is but slender. Instantaneous death is a rare occurrence. Even when it is sudden, for those standing by the minutes may seem to be hours. In the great majority of cases, however, there is ample warning, after which it is a matter of hours, rather than of days.

Although in the early stages of such cases it may not be possible to decide that the process of dying has actually begun, this uncertainty is soon dispelled and the sure signs of approaching death become unmistakable. These signs have been known for ages and have been described with wonderful accuracy in our most enduring literature.

The *facies Hippocratica* is perhaps our earliest picture of a patient *in articulo mortis:*

> the nose sharp and pinched, eyes sunk in orbits and hollow, ears pale, cold and shrunken with lobes inverted, face pallid, livid or black.

Shakespeare's account of the death of Falstaff is still more vivid. The hostess says:

> 'A made a finer end and went away an it had been any christom child. 'A parted even just between twelve and one, even at the turning o' the tide: for after I saw him fumble with the sheets, and play with flowers, and smile upon his fingers' ends, I knew there was but one way; for his nose was as sharp as a pen, and 'a babbled of green fields. "How now, Sir John!" quoth I; "what, man! be o' good cheer." So 'a cried out, "God, God, God!" three or four times. Now I, to comfort him, bid him 'a should not think of God; I hop'd there was no need to trouble himself with any such

thoughts yet. So 'a bade me lay more clothes on his feet. I put my hand into the bed and felt them, and they were as cold as any stone; then I felt to his knees, and so upward, and upward, and all was as cold as any stone.[1]

Sir Henry Halford's description of the dying patient, although a century old, has not been surpassed:

the eyes glazed and half closed, jaw dropped and mouth open, cold and flaccid lip; cold clammy sweats on head and neck; respiration hurried and shallow or slow and stertorous with rattle; pulse irregular, unequal, weak and immeasurably fast; prostrate on back, arms tossing in disorder, hands waved languidly before the face or grasping through empty air, or fumbling with bedclothes.[2]

These classic descriptions of approaching death should serve in every medical student's memory as pegs upon which to hang such modifications of the picture as his future experience shall furnish. Before his diploma is given him I believe he should be required to hand in full reports of his observations of several deaths. Such a requirement might impress upon him the physician's duty of serving humanity at the going out as well as at the coming in. And surely the young physician needs every possible help in deciding when the actual process of dying has begun. For this decision devolves upon him. He cannot escape it except ignominiously, for the treatment of the patient must then be radically changed. Restorative measures have then become worse than useless.

[1] *Henry* V, Act II, scene 3.
[2] Sir Henry Halford, *Essays and Orations.*

The proper care of the dying really depends more upon the physician's appreciation of his patient's personality than upon his knowledge of the purely physical phenomena involved; and yet as such knowledge is the foundation of his usefulness at the deathbed it requires our first consideration.

The process of dying is a progressive, not a simultaneous, failure of the vital functions. This progress is usually from below upwards. Thus, sensation and power of motion as well as the reflexes are lost in the legs before in the arms. And in the intestinal canal, before the patient can no longer swallow, the anal sphincters relax, peristalsis ceases, and the stomach simply distends with what is swallowed. The folly, under such conditions, of attempting to give nutriment by either mouth or rectum is apparent; it will likely be regurgitated or immediately discharged. The folly of it becomes even more glaring when later there is at least equal chance that the fluids given by the mouth will run down the trachea. This is not an infrequent cause of the "death rattle," which even if it does not disturb the patient, as in fact it often does, is nevertheless a needless addition to the distress of the family. If the rattle is due to hypersecretion of the bronchial mucosa it can sometimes be stopped by the hypodermic injection of a large dose of atropine.

As long as the patient can swallow, water, either pure or mixed with sour wine, is all that should be given.

This should be offered with increasing frequency but in lessening amounts. Toward the last, after even a few drops would cause choking, if a gauze wicking, one end of which is held in a cup of ice water, is put into the patient's mouth it often will be gratefully sucked. Except for drawing in the breath, sucking is the first, as it is the last, instinctive action for the body's sustenance. Probably thirst is our first and last craving. The complaint just before death on the Cross was "I thirst." It is well to remember also that the sponge dipped in vinegar was the kindest possible offering.

Although in the last hours the patient's mouth is generally open, it must not be forgotten that the Biblical phrase of "the tongue cleaving to the roof of the mouth" is no empty figure of speech. It may happen now-a-days, as I can testify from my own suffering when supposed to be totally unconscious and near the end. Such misery, as well as every other discomfort in the mouth and pharynx resulting from lack of saliva, can be prevented by applying vaseline to the tongue, or perhaps even more acceptably by placing bits of ice, enmeshed in a strip of gauze, well back between the gums and cheek. This last is the procedure employed by the Soeurs Augustines, whose skillful ways of comforting the dying have been adopted by the British visiting nurses. As the ice so placed melts, the moisture therefrom evaporates without causing the discomfort that even a few drops of fluid would cause.

When, on the other hand, there is too much fluid in the mouth, from regurgitation, gauze wicking similarly placed often affords the needed relief. But in these cases it is imperative that the patient shall be turned upon his side to allow gravity drainage. This procedure should also be employed when stertorous breathing is caused, as it often is, by a falling back of the tongue. In fact, change of posture often relieves the dying patient's general discomfort. Never should it be forgotten that the reason why patients *in extremis*, or unconscious from whatsoever cause, so generally are found lying flat on their backs is simply because they are not able to make known their need of help or to shift themselves from that position. They may still appreciate the comfort that a change affords. For instance, when the respiration becomes labored it is a great help to lift up the upper half of the body, provided always that care is taken to support the lower back, and so to let the shoulders fall backward in order to give all possible freedom for chest movements. But, as Florence Nightingale pointed out in her famous "Notes on Nursing," it is also important to pillow the head so that the neck shall not flex on the body.

As the peripheral circulation fails and the body surface cools there usually is a drenching sweat, whatever the temperature or humidity of the surrounding air. This sweating is most profuse on the upper parts of the body, and on the extensor rather than on the flexor surfaces as in health. Sponging off this sweat with

cloths wrung out of diluted alcohol often comforts the patient.

However cold the body surface becomes, the dying are almost never conscious of cold — on the contrary, they usually feel too hot.

Once a nurse dying of pneumonia, whose body surface was icy cold, in answer to my question if I could do anything for her, said she wished I would take her in my sleigh to the top of a hill nearby, and let her lie in a snowbank.

Even when supposed to be unconscious the restlessness of the dying is often caused by this sensation of heat. As the surface cools, their inward temperature, instead of lessening as in ordinary collapse, rises high. Their tossings are often only their efforts to throw off the bedclothes. In this one respect the account of Falstaff's death is not lifelike. Lighter and less covering is what is needed — not artificial bed heaters from whose burning the patients may be unable to move away. Fresh air in abundance is of course essential. That it shall be kept moving is more important for the patient's comfort than the question of its temperature. A slow-running electric fan is what serves best, but the air should be fanned at right angles to and not directly toward the patient's face. I have never seen any comfort from the use of oxygen on such occasions.

The chamber should be well lighted as the patient enters the valley of the shadow. The dying, as long as they are able to do so, instinctively turn toward the

light. Some complain of the growing darkness. A dying consumptive once begged me to carry her from her shaded chamber out into the sunshine. I shall never forget her gratitude or her entrancement as she died looking straight at the rising sun.

As sight and hearing fail, the dying see only what is near and hear only what is distinctly spoken almost in their ears. They are often disturbed by sounds no longer distinguishable. Whispering within their partial hearing is unpardonable. They enjoy soothing music. In the Feier Abend Haus of the deaconess hospitals in Germany, where the dying are more beautifully cared for than anywhere else in the world, hymns are played for them on the organ in the adjoining chapel.

Dying is always easy at the last. However great the previous suffering, there is always an interval of perfect peace and often a period of ecstasy before death. Even in cases of angina pectoris, where in previous attacks the patients have longed for release from life, in the last attack there usually is far less suffering and even this is likely to disappear before loss of consciousness. When Dr. Pepper's heart finally failed he died smiling. Indeed, this cessation of pain is often a sign of impending death. All competent observers agree that there is no such thing as "death agony," except in the imagination. The contortions of the dying body, it is true, are sometimes distressing sights. They seem to be evidence of suffering, but it is seeming only. And yet many who are quite ready or even eager to leave this world dread the

act of leaving. Their fears of death are as needless as is the fear of being buried alive. Nevertheless, so common are these fears, even among otherwise intelligent people, that it is well for every physician to have at his tongue's end a full supply of fear-dispelling evidence. Here is some of it.

Those who have been rescued from death by drowning, even after almost hopeless hours of artificial respiration, always testify that before losing consciousness they experienced no suffering whatever. Such is also the universal testimony of those who have been revived from states of collapse, where to all appearance they were at the point of death. Those who are conscious to the very last invariably answer that they do not suffer. For instance, William Hunter, the great anatomist, who retained his consciousness to his last breath, just before he died whispered to his friend, Dr. Combe, "If I had strength enough to hold a pen, I would write how easy and pleasant a thing it is to die."

In Edward Hammond Clarke's *Visions*, posthumously edited and published by Oliver Wendell Holmes, the account is given of the death of one of his patients who had arranged to signal by finger movements, after he should become otherwise unable to answer. To the very last, after he appeared to have lost all consciousness, this patient signalled "No," in answer to Dr. Clarke's questions if he were suffering.

Many physicians who have made it their practice to stand by their dying patients have stated that they

never have had reason to believe there is any such thing as death agony or, in fact, any consciousness of suffering. Such has been my own experience.

One of the strong and comforting conclusions in a thoughtful study of the subject is that

> what is called death and the loss of sensibility are one and the same, and therefore the last act of dying can in no instance be an act of suffering.[1]

However painless the final stage, much discomfort and some suffering are only too possible in the earlier stages of dying. Much of this is avoidable. Some of it, as we have seen, is due to lack of proper treatment or to wrong treatment of the patient. In the latter case the harm is generally from failure to recognize that the treatment needed is radically different from what is appropriate when restoration is possible, as, for instance, in giving nourishment and stimulants when there is no longer any possibility of their absorption but great danger of their regurgitation; or in applying artificial heat after the heat regulation of the body fails. All such disturbance of the dying patient is inexcusable. It may be easier in such a case, as it often is in other exigencies, for the physician to surrender his own judgment of what is best for the patient to the prejudices or desires of agonized relatives, who do not understand and so cannot accept the facts. All of the physician's patience, tact, and sympathy are then needed, and, above all, his firmness. If he is unremitting in his attention to the patient

[1] A. P. W. Philip, *An Inquiry into the Nature of Sleep and Death*, p. 228.

he will eventually win the confidence and gratitude of the family; and meanwhile, what is of far more worth, he will have the satisfaction of knowing that he is doing as he would be done by.

Besides the frequent causes of the dying patient's discomfort already mentioned, there is the possible bladder distension to be looked out for. This may occasion acute suffering. More often by its dribbling overflow there is the discomfort of a wet bed and foul odors. After patients are no longer able to make known their wants they sometimes recognize the opportunity afforded by a properly placed urinal. If too far gone for that, catheterization may give great relief. But in my experience that has been very seldom necessary, and in some cases it has seemed only an aggravation.

Fortunately, the discomfort and suffering of the dying almost always can be relieved by medical treatment. The occasional serviceableness of atropine has been mentioned. Opiates are indispensable. If opium, as the Arabs believe, is a direct gift of the gods, surely the possession of its soluble alkaloids and of hypodermic needles is an equal blessing. If morphine fails to give comfort to the dying, a hundred to one it is either because too small doses have been given or because it has not been successfully introduced into the progressively enfeebling circulation. Large and frequent doses may be needed. There is no limit to the amount that may properly be given. As the end approaches, a full grain is not too much of a dose. And if the needle cannot find a vein,

it is always easy for a long needle to reach the heart. Ordinary subcutaneous injections are of course useless. Morphine toward the last will not slow the hurried respiration, but it will often stop a strangling cough and the far more distressing regurgitation. Its main effect is its soothing influence. This, in part, may be due to cardiac stimulation. For this purpose it has no rival. All of the usual heart stimulants on these occasions are worthless. Massive doses of morphine given to the dying, instead of hastening the end, seem rather to postpone it, and, instead of narcotizing, not seldom seem to enliven the patient's consciousness.

Perhaps enough already has been said to prove the need of constant medical attention to the dying. Under proper direction, the nurses can give most of the service needed, but it is unfair to expect it of them unless in the execution of direct orders, which very likely may have to be frequently changed. Even if no such active measures of relief are needed, that very fact is for the physician to decide. In such cases it is for him to protect the patient from the disturbance of officiousness:

> Disturb him not, let him pass peaceably.[1]

But when only watchful waiting is needed, the physician must not underrate the help his mere presence may afford in steadying and comforting both the dying patient and the family. When apparently doing nothing, he yet may be doing much.

> They also serve who only stand and wait.

[1] *2 Henry VI*, Act III, scene 3.

Thus far we have considered only the physical phenomena of dying. Such knowledge is essential, but right treatment, as already has been said, depends still more upon the physician's appreciation of his dying patient's personality. Such appreciation indeed is the foundation of the art of medical practice. It distinguishes the physician from the veterinary. And these suggestions regarding the proper physical treatment are of little importance except as they furnish the doctor sufficient reason for standing by the death-bed of his patient. Such indeed is the real value of much that we do in our practice of the healing art. Often it matters little what medicine is given, but matters much that we take advantage of the opportunity to give ourselves with our pills. Discretion of course is necessary in all ordinary personal relationships. But when we are caring for the dying no caution is needed in the use of our hearts. Until the doctor has had the sad experience of taking care, to the very last, of those nearest and dearest to him, he can only imagine the heartache of his dying patient's family and their sore need of sympathy; nor until he himself has been nigh unto death, can he more than imagine the comfort that the firm clasp of a kind hand can give to one in such extremity.

While the patient's health is restorable or even while his life can be prolonged by purely scientific treatment, the absence of any interest in his personality may not be noticeable. But when the body is nearing its end, especially when consciousness continues to the last, and

when as often happens in such cases the real character of the patient shines forth more plainly than ever before, then it is that materialism reveals its utter helplessness.

This is not the occasion for any discussion of the continuance of the soul's life after bodily death. But no adequate consideration of the proper care of the dying is possible without emphasizing the difference between the patient's soul and his body. Agnosticism regarding a future existence, or even absolute disbelief of it, never can absolve the physician from devoting his attention to his dying patient's personality.

Before outlining this higher service that can be given on such occasions, it is necessary to consider the various mental conditions of dying patients. They vary all the way from absolute unconsciousness, dating for instance from the breaking of a large blood vessel in the brain, to perfect consciousness until the last flutter of a failing heart. Unconsciousness, however, may be only apparent. Moreover, just before death occasionally there are very remarkable recoveries of consciousness,[1] which perhaps may be due to the relief of blood pressure in the brain as the heart fails. In such cases it sometimes happens that the patient is found to have heard what has been said at his bedside, while to all appearances he was totally unconscious. Both these extremes, of total un-

[1] For such instance, *vide* Sir Henry Holland's *Medical Notes and Reflections*, p. 34, and Sir Henry Halford's *Essays and Orations*.

consciousness from the first and of full consciousness to the last, are rather rare. Usually in the process of dying there is a gradual loss of consciousness, the onset and progress of which is only with great difficulty distinguishable from the patient's increasing disability to communicate his thoughts. Long after his whispered words have become inaudible the patient may be able to signify assent or dissent by slight movements of the head. Still later only the eyes are able to reveal the dying mother's love for her children. This final loss of all communication with the world may precede death by many hours or only by moments. It may not happen until after the last breath has been taken. Of this, I was once made perfectly sure. The patient's hand, after she stopped breathing, was tenderly laid upon the head of her weeping friend kneeling at the bedside.

Evidence of this retention of consciousness to the last, as might be expected, is rarely found. It seems to have escaped the notice of otherwise acute observers, who naturally have concluded that a longer or shorter period of unconsciousness always precedes death. But for it there is strong testimony. For example, Sir Benjamin C. Brodie says:

> I have been envious to watch the state of dying persons . . . and I am satisfied that where an ordinary observer would not for an instant doubt that the individual is in a state of complete stupor, the mind is often active at the very moment of death.[1]

[1] *The Works of Sir Benjamin C. Brodie*, vol. i.

This opinion is endorsed by Dr. William Munk in his "Euthanasia." [1]

Such testimony weighs heavily against that of Sir William Osler's nurses who, at his request,

> for some time took down the exact words of dying patients. The great majority gave no sign one way or the other—"like their birth their death was a sleep and a forgetting." [2]

It would be interesting also to know what these nurses noticed in the small minority of their cases. And it may further be observed that "a sleep and a forgetting" is more characteristic of *still* than it is of *live* births.

No study of the mentality of the dying would be complete without discussion of their visions. In his essay on this subject, previously mentioned, Dr. Clarke explains these visions as probable instances of automatic pseudopia. But, after quoting reports of cases presenting phenomena "of which, to say the least, it is difficult to give an adequate physiological solution," he reports such a case that occurred in his own practice. These are his words:

> The departing one was a lady of middle age. Her death, though momentarily expected from cardiac disease, was not announced or preceded by the usual anaesthesia of the dying. During the night, when awake her mental action was perfect. She conversed, a few minutes before dying, as pleasantly and intelligently as ever. There was no stupor, *delirium* strangeness, or *moribund symptom*, indicating cerebral dis-

[1] Wm. Munk, *Euthanasia: or Mental Treatment in Aid of Easy Death*, p. 47.

[2] Harvey Cushing, *Life of Sir William Osler*, i, 599.

turbance. Her cardiac symptoms alone foreshadowed the great change. After saying a few words, she turned her head upon her pillow as if to sleep, then unexpectedly turning it back, a glow, brilliant and beautiful exceedingly, came into her features; her eyes, opening, sparkled with singular vivacity; at the same moment, with a tone of emphatic surprise and delight, she pronounced the name of the earthly being nearest and dearest to her; and then dropping her head upon her pillow, as unexpectedly as she had looked up, her spirit departed to God who gave it. The conviction, forced upon my mind, that something departed from her body, at that instant rupturing the bond of flesh, was stronger than language can express.

The name pronounced by this patient of Dr. Clarke's was that of an "earthly being nearest and dearest to her." If this was one no longer living in this world the incident would accord with common experience. Such visions are generally regarded as portents of impending death. So common are they that no wonder is excited by them: they seem but the natural prelude to the patient's departure. Several such instances that have occurred in my own practice will serve as examples.

An aged widow, who in spite of cardio-renal embarrassment had been able to be up and about, feeling uneasy, asked a neighbor to stay the night with her. It was well; for she died before morning. When I asked the neighbor watcher if she had noticed any signs of impending death, "Oh, yes," she said, "the poor soul was perfectly happy and was talking to her husband off and on through the night, as if he were really lying beside her."

Once on my hospital visit, I found a patient propped up in bed, smoking a cigarette and reading the morning paper. He seemed to be convalescent after an appendectomy a week earlier. As I left his room the nurse stopped me to report that the patient had been talking to some visitor invisible to her, who he said was dressed in white. I went back to ask him about it. "Oh, it was only my sister," he answered casually and went on reading the newspaper. His sister had died previously, yet her presence seemed to him merely a natural fact. A few hours afterwards, without any other warning, his heart suddenly stopped beating.

In neither of these cases have I any reason to think that the one dying had any sure belief in the reality of the after-life. They were not religiously inclined. But in the case I am now to describe, such a belief and inclination was my uncle's very life. For nearly a year he had been suffering the usual ups and downs of pernicious anaemia. His mind had continued wonderfully clear. No sign had appeared that his death was near. He was apparently wide awake. Suddenly, he half rose from his couch to greet his father who had died many years before. His face was radiant with joy, as he called to me to join in the welcome of his visitor. Evidently disturbed by my hesitancy, he asked anxiously, "Did you not see your grandfather?" and when I had to say that I did not, he added, "Why I recognized his footfall before he opened the door." I had just finished a letter saying I saw no reason why my uncle should not live for months to come, but I added a postscript, telling of the vision

and of my belief that the end would come very soon, as it did.

Whatever may be the true explanation of such visions, they certainly afford great comfort to those who accept them as evidence of the reality and nearness of those who have gone before. So, too, do the last words or looks of the dying, when they seem spoken or directed beyond this world. Those less credulous and yet wanting to believe will ask, with Dr. Clarke,

> If life is continuous, heaven beyond, and death the portal, is it philosophical to affirm that no one entering that portal has ever caught a glimpse or can ever catch a glimpse, before he is utterly freed from the flesh, of the glory beyond? May not the golden bowl, just as it is shattered, be touched by rays from a light that is above it and flash with a glory no language can describe? . . . Silence, surprise, wonder, and rapt gazing would be natural to anyone, even at the moment of dying, upon whose view such a scene should burst. There would be no revival of brain cells, stamped with earthly memories and scenes, but something seen, of which the brain had no antecedent impression, and of which the Ego had formed no conception. It is in some such direction as this, if in any, the departing spirit would indicate, just as the old is dropping off, that the new is seen. Entranced by a glimpse of what eye hath not seen, nor ear heard, and of which man has formed no conception, his gaze would be riveted upon a glory, invisible to his earthly companions. His features would be transfigured. . . . Such should, and such must be, the ineffable expression of transfigured humanity upon the features of whoever gets a sight of heaven, before he has left the earth. If ever a scene like this occurs, who will dare say that the explanation of it may not come from a height inaccessible to our imperfect physiology? [1]

[1] Edward Hammond Clarke, *Visions*, pp. 272 et seq.

The foregoing sketch, despite its crudity, of the dying patient's changing mentality may yet serve as a basis for further consideration of the physician's opportunity for service at the death-bed.

If no more than mere mention is made of the consolation afforded by a religious faith in the future life and Divine forgiveness, it is only because this subject is generally conceded to belong to the clergyman rather than to the physician. But from those having no church affiliation we need never be surprised by appeals for upward guidance. The dying do not always recognize the difference between the clerical and medical professions. They seem also unable to distinguish between their need of physical relief and that of consolation for their souls.

My present purpose, however, is to point out, not what comfort can be given the dying by others, but rather what the physician should be peculiarly able to give.

As we have already noted, it is the physician's function to decide when all treatment designed for restoration shall be replaced by what more likely may comfort the patient. With this decision a still more perplexing question arises — whether or not to tell it. Devotion to the truth does not require the physician always to voice his fears or to tell his patient all he thinks he knows. But, after he has decided that the process of dying has actually begun, only in exceptional circumstances would a physician be justified in keeping to himself his opinion. In such cases his only questions should be whether to

tell the patient or the family, and, when both are to be told, which to tell first.

Most dying patients have the feeling that death is near. Some know it well enough and yet want nothing said about it; or perhaps, while they like to talk of it with the doctor and nurses, they cannot bear to speak of it to their families. Some families, on the other hand, prefer not to be told the truth and are particularly anxious lest anything may be said that might alarm the patient. In other cases, perfect frankness all round is what is wanted. This is really a comfort at the time, as well as afterwards, to the bereaved. While decided family preferences are entitled to utmost consideration, there are certain obligations that require the physician to disregard them. For instance, either the patient or the family, or both may believe in the necessity of religious preparation for death. In such cases the physician is bound to give timely notice and also every facility for such ministrations.

There may be some ground for the complaint occasionally heard from clergymen that, instead of being summoned as they should be for such service, they are debarred by the medical attendants on the ground that such pastoral visits would frighten the dying. A sufficient answer to this complaint against us is that Catholic priests would very properly ignore any such barriers.

Much of the uncertainty as to what should be said or left unsaid on such occasions is owing to general igno-

rance of the fact that death is almost always preceded by a perfect willingness to die. I have never seen it otherwise, even where the circumstances of life have made its continuance seem most desirable. This acceptance of approaching death is its natural accompaniment. As Sir Henry Holland well says:

> No previous reason or feeling can afford a right estimate of the relation the mind assumes to death in the later hours of life, even where no impairment of its faculties has occurred. This is especially true when long and painful sickness had been the prelude to the event. But the exhaustion from acute pain of short continuance alters this relation; and even without sickness or suffering of any kind the mere diminution of vital power by the decay of age produces the same effect. The earnestness to live abates as the possession of life is gradually withdrawn.[1]

With this knowledge the physician ought not to find it hard to establish with his dying patient and family absolutely frank relations, which will be an immense advantage in carrying out the proper treatment.

Our human nature is such that uncertainty is hardest to bear. And much of the frantic distress of the family, which, if allowed expression, would be disturbing and unfair to the dying patient, can be kept hushed by plain talk from the physician. They can smother their sobbing if they are told that the dying patient, although apparently unconscious, yet may hear and know all that is going on. And even on the remote chance that their loved one will again be able to see them, if for only a

[1] *Medical Notes and Reflections*, p. 170.

moment, smiles can be made to keep tears from overflowing.

No small part of the physician's duty, and privilege, in attending the dying is to steady and comfort the stricken family. This can best be done by giving each one some share in the nursing service. Even if clumsier, their touch may be far more grateful to the patient than that of the most skilful nurse. And, if only for their sakes, whatever they can do they should be allowed to do.

In the life story of the greatest physician any of us has ever known, which has been so well told by our own Harvey Cushing, there is a lovely picture of his wonderful appreciation of personality. It is the mother's account of Dr. Osler's care of her dying child:

> He visited our little Janet twice every day from the middle of October until her death a month later, and these visits she looked forward to with pathetic eagerness and joy. . . . Instantly the sick room was turned into a fairyland, and in fairy language he would talk about the flowers, the birds, and the dolls. . . . In the course of this he would manage to find out all he wanted to know about the little patient. . . . The most exquisite moment came one cold, raw, November morning, when the end was near, and he brought out from his pocket a beautiful red rose, carefully wrapped in paper, and told how he had watched this last rose of summer growing in his garden and how the rose had called out to him as he passed by, that she wished to go along with him to see his 'little lassie.' That evening we all had a fairy tea party, at a tiny table by the bed, Sir William talking to the rose, his little lassie and her mother in a most exquisite way . . . and the little girl understood that neither

fairies nor people could always have the color of a red rose in their cheeks, or stay as long as they wanted to in one place, but that they nevertheless would be happy in another home and must not let the people they left behind, particularly their parents, feel badly about it; and the little girl understood and was not unhappy.[1]

If our eyes moisten over this example of perfect practice of our art, let no despair from being so far behind this great master of it prevent us from following such leadership. Above all, let us ever remember that our duty to our patients ends only with their death, and that in the hours preceding it there is much that we can do for their comfort. At the very least, we can stand by them.

[1] Harvey Cushing, *The Life of Sir William Osler*, ii, 620.

IX

Attention to Personality in Sex Hygiene

By Alfred Worcester, M.D.

THE personal relationship between a physician and his patients is of importance in proportion to the nature and severity of their diseases.

For patients who are acutely ill or suffering physically, if the doctor brings to bear all the relief that modern science affords, that is generally enough; and yet sometimes in such cases there are also grand chances for first-aid treatment of the soul.

But it is in the care of chronic patients, and still more in the care of those hardly over the border line of normality, that the insufficiency of impersonal treatment, however scientific, is simply appalling.

In any of the branches of medical practice it would be easy to find illustrations of this supremely important difference between the personal and the impersonal treatment of patients, that is, between the art and the science of medical practice. Such illustrations in some branches would be more vivid than in others. Perhaps the best background for them is to be found in the modern specialty of Preventive Medicine, where the rôle of the physician is that of counsellor rather than that of restorer.

Among the sub-divisions of this great field of Health Preservation I have chosen that of Sex Hygiene for the development of my thesis. One reason for this choice is my conviction that nowhere else is attention to the patient's personality so absolutely essential to the physician's usefulness. Another reason for choosing this subject is that it is so generally shunned and neglected.

While parents and teachers are begging for our leadership in this field, how little attention is given to it in preparation for practice! The young physician of course knows all about the treatment and prevention of venereal disease; he may know more or less about sexual perversions; but very little can he be fairly expected to know about safeguarding the development of sexual integrity.

In fact, before we begin to discuss the opportunities for service in this field, we must try to reach some common understanding of the principles of sex hygiene.

As biologists we need not be confused by the multifarious dicta of the moralists upon this subject. On the contrary, we can insist that sexual morality, if ever it is to escape from chaos, must have its basis sought for in physiology and psychology.

Biologically considered, human creatures are only separate offshoots from the great life-stream; and the main purpose of their existence is the protection of this germ-plasm in order that its transmission shall be unimpaired. This biological obligation rests in exactly equal degree upon both sexes, not separately but con-

jointly. Thus for each sex there is double responsibility.

After countless ages of experimenting with different ways of mating, which, by the way, in all their variety can still be seen in operation, the races that have attained highest civilization have found that this obligation can best be met by monogamy. Not only the best physiological and psychological conditions are to be found in such family life but also the greatest human happiness. And, inasmuch as our main purpose as physicians is to protect and promote health and happiness, the essence of sex hygiene is the elimination of every interference with the perfect mating of the sexes.

Over some of these impediments we have no control, as, for example, the postponement of marriage beyond the proper mating time. This seems to be the inevitable consequence of the long years required in preparation for life work — as needs not be emphasized before this audience. In such cases all we can do is to minimize the detriment.

Among other impediments to proper mating is ignorance of what ought to be matters of common knowledge. For such ignorance the medical profession is at least partly to blame. For it is as much our business to point out the safe road as it is to warn our fellow travellers of the pitfalls that line the roadway, or as it is to pull them out after they have fallen in.

Such instruction, graded in accordance with the pupil's inexperience, depends for its efficacy upon the

teacher's knowledge of each pupil's individuality, that is, upon the physician's recognition of each patient's particular status, however hidden it may have been by modesty and reticence.

Fortunately for our profession, our patients more readily make us rather than others their confidants: fortunately, too, young folks now-a-days are far more outspoken in such matters than were their elders. Far easier will it be for you than it was for your seniors to find out what boys and girls know and don't know about their sexual instincts and responsibilities.

Some years ago leading educators advocated the teaching of sexology in the public schools. They believed that such knowledge would protect future generations from disasters, supposedly due to ignorance, that had fallen upon their predecessors. The advocates of such public teaching were fiercely opposed by those who confused innocence with ignorance. And the question how far such instruction is advisable has not yet been settled, as may be seen in the latest textbooks on Hygiene. In some of these, full explanations of the functions of the genital organs are given, together with anatomical illustrations, while in others the subject of reproduction receives scant consideration.

The objectors to giving public instruction in sexology have, however, some good ground for their opposition. In the first place, it is worse than useless to direct attention to the subject prematurely. For the sexual nerve-centres are only too easily excited by the imagination,

and sexual perversions are the natural consequences. Moreover, the danger is great that the child's natural curiosity, stimulated by such instruction, will lead to seeking further knowledge from associates whose ignorance alone excuses the transmission of evil misinformation.

These dangers, it is to be noticed, are not inherent in the knowledge itself, but in the mistimed and misdirected teaching of sexology. And the fault of that lies in disregard of the individual needs of those being taught. The physician is very liable to just this fault. Without a thorough understanding of his patient's real self, his advice may not be understood or, worse yet, may be misunderstood.

In simpler stages of civilization, where mating is not impeded by economic considerations, we can easily believe that the sexual instincts are less insubordinate. But in the complex life of our modern world the importance and the prevalence of miseries occasioned by their mismanagement can hardly be exaggerated. In fact they are so widespread that any man or woman who has entirely escaped these miseries must be considered exceptionally fortunate. And yet, because they are so deeply buried, these troubles are generally believed by those who bear them to be their own peculiar private burdens.

I am not speaking now of what may have been buried below the consciousness of the individual. On the contrary, I must frankly admit my ignorance of the "sub-

conscious mind"; and I am offering for your consideration rather those troubles that are being deliberately concealed.

Such troubles vary enormously. They may be entirely imaginary. And yet, when without any pathological basis, they may nevertheless ruin health and happiness. Often the burden of such troubles, as I shall point out later, can be lifted simply by confiding them to a physician. Where then could be found stronger need than here of medical attention to personality, and where could a physician find larger opportunity for service?

Merely by acquainting the sufferer with the fact that his burden is only what all have to carry, it is often possible to take off half its load. And still further relief can almost always be given by explaining that no one is responsible for the possession of his instincts, but only for the control of them, and that everyone should be proud instead of ashamed of possessing sexual instincts.

The opportunity of affording relief by such medical teaching depends upon first winning the patient's absolute confidence. This, in turn, depends very largely upon the art of sympathetic listening. The physician must actually feel the timid child's agony in disclosing his secret woe.

No notes can safely be taken in such a patient's presence. No other such effective destroyer of professional intimacy was ever invented. If sitting side by side, it will be easier to hear the patient's faintest

whispers; and for the patient, self-revelation will thus be easier than when facing the doctor's scrutiny.

Perfect sympathy prevents the fault of making light of what to the physician may seem trivial but which to the patient may seem unbearable. It also prevents showing even in the least degree any natural feelings of disgust or revulsion when the disclosures are shocking. In either case the lack of sympathy, or, in its absence, any pretence of it, will surely be felt by the patient and as surely will defeat all efforts to help him.

Saving a fellow creature sunk deep in the mire depends first of all upon his rescuer's *reaching* him. It also depends upon the rescuer's having firm foundation for his own feet. Despite all our knowledge of disease causation, the doctor still is always in danger of infection. Of this we here have lately had sad illustration. But it is not deadly germs that we are now considering. Nor is it the very real danger of appropriating for one's self the symptoms of our patients' diseases.

In the whole range of medical practice I know no severer test of professional ethics than that which confronts the physician in the treatment of sexual irregularities. For his own safety, if indeed only that were ever to be considered, the doctor might be excused for dodging such patients, or even for giving them only cold impersonal attention. For, in the sympathy that I am pleading should be felt for them, and also shown them, there are, it is only too true, personal dangers which cannot be ignored. But the physician has not only his

own honor at stake: he also has at stake the honor of a noble profession. There is mighty help in remembering that!

As ought to go without saying, physical examinations of patients of the opposite sex should never be made in the privacy that is essential for the consultation. Nowhere else is our profession so deeply indebted for the assistance of trained nurses. Without them no doctor's office is properly safeguarded. You younger brothers cannot imagine how much more hazardous our practice was before such assistants were available. You will hardly believe that when I began practice I was begged by my seniors, one of them the president both of the Massachusetts Medical Society and of the Obstetrical Society of Boston, never to examine the uncovered female genitalia except when the patient should be under full anaesthesia and on the operating table.

No one now-a-days can have any appreciation of the fierce antagonism the early gynecologists encountered. But as we look back, we can see that part of this opposition was justified. For, in exclusive attention to the possible physical basis of sexual irregularities, the accompanying disregard of the patients' personalities not infrequently worked more harm than good.

Immense benefit in these later years has resulted from the replacement of "medical gynecology" by surgery. Under anaesthesia the treatment that used to spin out for weeks or even months can now be given promptly and without endangering the patient's personality.

In the occasional case where physical defects that can be corrected are the probable cause of sexual irregularities, or even of the patient's over-attention to the sexual instincts, surgery may afford entire relief. But no greater mistake can be made than to suppose that removal of the cause will surely eliminate its effects. Such patients almost always need more than physical reconstruction. After the total removal of the genital organs the impress made by their previous disorders may persist in the patient's consciousness. Indeed, such misfortune might continue even were it possible in this extirpation also to include the sexual reflex centres in the autonomic nervous system.

Where could we find a more vivid illustration of the difference between the patient's body and the patient's self, and also of the vastly greater relative importance of the latter!

Without emphasizing the immense benefit to womankind of modern gynecology, it would be unfair to use this specialty for illustrations of the disastrous consequences of exclusive attention to local physical conditions. The only point I want to make is that in this specialty inattention to the patient's personality is fraught with peculiar danger.

The sexual instincts seem to belong to us more intimately than our other instincts. They are also more unmanageable. Our other appetites serve only our own ephemeral existence: these serve the perpetuation of the human race. Consequently, in the normal reproduc-

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tive functions there is for the creature the nearest approach to coöperation with the Creator, marked by the highest physical ecstasy. And in the promptings of these instincts, if rightly interpreted, originate our noblest emotions.

In my description of this field of sex hygiene I have already outlined some of the troubles and miseries that challenge the physician for redress. It is time now to look at some of these woes of the flesh more in detail, in order to see how relief from them depends entirely upon our study of each patient's personality.

The earliest misuse of the sexual instincts is the artificial incitement of their reflex nervous centres. Masturbation in one form or another is so nearly universal that it can hardly be considered as abnormal. It seems to belong naturally to the puppy stage of animal development. Although practically harmless, so far as the body alone is concerned, its effects upon the personality are sometimes pitiably serious.

In the developing maturity of the child the sensory gratification from such incitements increases at a faster rate than the power of self-control. Even without the additional fear of its dire consequences, as falsely taught by charlatans, the victim of this habit is very liable to suffer undue self-humiliation. Life may become unendurable and death may come to seem the only escape from such thraldom.

Worse than useless for such patients is any form of treatment that might aggravate their self-fixation.

Instruction and diversion is the sovereign combination remedy. And this, be it noted, has to be given in different form according to the widely ranging needs of these patients. How, pray, can these individual needs be known by the doctor, except by diligent attention to such a patient's personality? For one, help may be given by physiological explanations of the sexual reflexes, while for another only further incitement of their mental sexual centres would result from such teachings. Stimulation of the patient's pride helps one; encouragement of the natural desire for full maturity helps another; and whatever fosters athletic ambition is helpful to many more.

But underlying all curative expedients the foundation principle, as I have insisted, is that of instruction and diversion. Every patient must be taught to utilize the first glimmering inclination toward such indulgence as a danger-signal that imperatively requires some other action. Little does it matter what this alternative shall be, but it is of all importance that such activity shall be definitely prescribed. Failures to follow these orders are to be forgotten: only instances of obedience are to be recounted by the patient.

Unfortunately, few of these patients come to us of their own accord. Most of them come under duress, and often only after they have been cruelly mistreated. Some have been punished as if they were criminals; others have been so shamed and frightened that they come to us trembling with fear and mortification.

For such victims it is, of course, first necessary to rectify so far as is possible the damage caused by previous mistreatment. Nor is it an easy task to build up a patient's shattered self-respect, or to dispel his groundless fears. Only after winning the patient's perfect confidence will it ever be possible to give wise and beneficial advice. Never will it be right to let him believe that the habit is of no consequence, and that it will make no difference in his acquirement of full maturity whether or not he wins the mastery over his sexual instincts. Encouragement rather than maudlin sympathy is what is needed.

In the saddest of all these cases, where the habit of self-abuse has been viciously implanted in the very young, curative treatment of course depends upon the coöperation of parents, nurses and teachers. They must be taught the folly of shaming and punishing the child. They must, instead, be taught how to employ the principle of diversion. Properly treated, such little victims of the wickedness of sex-perverts can be rescued before any lasting impress is made upon their memory.

Before leaving this part of my subject, surely it is superfluous to reiterate the supreme importance in these cases of sympathetic attention to the personality of our patients rather than of mere scientific interest in their misfortunes.

During the masturbation stage there is safety in the secrecy of the habit, and dangers in its publicity. One of these dangers is that others, too young for the natural

or accidental development of the habit, shall acquire it long before they are old enough even to want to get rid of it. A greater danger is that comrades aware of each other's addiction shall fall into the far more serious habit of homosexual indulgences. This, like all other sexual perversions, is due to the insufficiency of sexual power by reason of immaturity or arrested development.

Unlike masturbation, which in humans as well as in other animals comes to its natural end under the powerful attraction of the opposite sex, the habit of homosexual indulgence meets with no such natural termination. On the contrary it prolongs, perhaps throughout the victim's lifetime, the aversion for the opposite sex that normally characterizes the early stages of sexual development.

Again unlike masturbation, homosexual practices are ranked as crimes. If only because of the habit's anti-mating effects and of its contagiousness, it perhaps deserves the hostility of society. But how about its young victims who have succumbed to adroit seducers? And this is only one of the puzzling questions confronting the physician who has to treat such patients. No two cases are alike; nor for this disease is there any antitoxin or other specific treatment. In his study of such cases the physician will have no help from the laboratories, and not much more from the libraries.

If the patient is below par physically (perhaps as a contributory cause or perhaps as a consequence of his demoralization), that will be found to be a help rather

than a hindrance to his physician. In the treatment of the weak body there are just the chances needed for treatment of the patient's weakened will.

Without further consideration of these pitiable human wrecks, is it not plain as day that the only hope of rescue depends upon the physician's devotion to the patient's personality?

As may have been noticed, in these illustrations taken from the field of sexual perversions, I have as yet made no distinction between male and female patients. There has been no need of so doing, nor will there ever be any use of trying to estimate the relative incidence of such troubles in the two sexes. In the treatment of such cases the secrecy of the confessional will always be essential. Where unfortunately the dereliction is known by others, the physician's task is more than doubled, for then he has to secure their coöperation as well as that of the patient.

The essence of sex hygiene, as you will remember I have defined it, is the prevention of all impediments to the perfect mating of the sexes. And now, leaving these particularly distressing topics, let us turn to the consideration of unlawful sex matings.

In the past, and perhaps still in some quarters, the medical profession has been charged with advising coition outside of marriage as a not improper and as perhaps a physiologically necessary procedure. I myself have never known a physician who would give such advice or who would admit that it is ever necessary or

allowable to give it. As you doubtless know, all the reputable medical societies take this stand. But the negative influence of the medical profession is not enough. Positive teaching is needed by every new generation; for each brings in new phases of the same old problem.

Formerly this question of privilege for unlawful sexual gratification was discussed as if it concerned men alone. Women's interests were ignored, and also their sufferings. And now, although in their modern independence every question of privilege and penalty must be discussed on the plane of sex-equality, we still shall find in our study of such sexual irregularities that the burden of them always bears far more heavily upon women than upon men.

But the man who imagines that by such indulgence he does not impair his chances of a subsequent perfect marriage is simply mistaken. I shall not even mention the dangers of infection or of legal entanglements. I ask you to consider rather the man's loss of self-respect, the lowering of his ideals, the sacrifice of his inborn chivalry, and the still more serious violation of his parental instincts.

All these sad consequences of unlawful coition are glaringly revealed in the remorse of the first-time offender. Nine times out of ten, as it behooves us to notice, this first offence occurs only when the young man's inhibitions have been benumbed by alcohol. If there is any larger opportunity than such cases afford

for the doctor's friendly service, I have not found it. Nor can I imagine any cases where impersonal service would be more inadequate. Such treatment would at best serve only to dispel the patient's probably groundless fears of infection or of future legal liabilities, without any consideration of his personal damage, which is of far greater importance. But do not imagine that I am presenting such a case as an opportunity for moral homilies. Not that I underrate the powerful aid of religious stimulation, but I ask you to consider it as the best chance a Sanatarian can ever have of rescuing a fellow man from further unfitness for a subsequent happy marriage.

Turning now to the effects upon women of illicit coition, we shall find them, as I have already said, more detrimental than the effects upon men. The maternal instincts are stronger than the paternal and therefore more suffering is caused by their violation.

The young girl's longing for a baby of her own, although very likely unrecognized, is not seldom the cause of her ruin. Or, if of feeble mentality, her intense maternal longings may make her the boy's seducer. If an illegitimate pregnancy results, the girl's future is less in danger than if she escapes this natural penalty; for then she will be given at least some fraction of the protection she should have had before, whereas otherwise, after such sexual stimulation, she can be saved from further downfall only by the kindest unremitting care.

The physician is the natural protector of such girls. In him they will most readily confide. They seem to know that he will at least not blame them for having surrendered to their overwhelming sex urge. And even after the undeserved abuse so often accorded, which may have driven them into the streets for their daily bread, such women are often more redeemable than are the men who have made use of them.

Owing perhaps most largely to the changed economic status of womankind during the last half century, prostitution has largely disappeared, at least in this country. I therefore need hardly mention the customary but mistaken pessimism as to the chances of a prostitute's redemption. Under the tongue-lashing so generally bestowed upon them such women of course became Ishmaelites. But under wise and kind treatment many more than is usually supposed have become useful and respected members of the society that had stamped upon them.

Many an old doctor, out of his unrecorded cases, could testify of what probably at the time seemed to him to be the miraculous effect of the humane treatment of such unfortunates, and he could also testify of his rich reward in the grateful friendship of the self-respecting women that they became.

Undoubtedly the disappearance of the brothels, and of their segregated districts, is in no small measure due to the abolition of the saloons, of which they were the natural adjuncts. In some measure this fortunate

disappearance is also due to the increasing political power of women who were determined to efface this blot upon civilization.

But those who maintain that the result of this reform has been only the dispersal, and not the eradication, of the social evil, have more ground for their pessimism than we well might wish. And in our study of the subject, in order to envisage our medical opportunities for personal service to those in need, we must also consider the not infrequent indulgence in secret liaisons by women economically independent and of excellent intellectual endowment, who for one reason or another have not married.

Without husbands or children of their own to love and cherish, and with all their natural yearnings unsatisfied, such women may have deliberately determined to accept temporary and clandestine lovers. Some never seem to regret it. But the undue intimacy, thus allowed, involves serious dangers. Besides the effects of continuous fear of a resulting pregnancy or of other exposure, there is the larger risk of a nervous breakdown from the strain of such incomplete mating.

The physician is the natural confidant of such patients. Their appeal to him is not only for medical advice, but rather for the sympathy they would never even think of asking from others. Very often these patients never directly disclose the real cause of their misery, nor would they repeat their mute appeal for sympathy and guidance to any such blunderer as might pry into their secrets.

Akin to the sufferings of those who cannot reveal their history is the torment that others in silence bear of unsatisfied sexual cravings. Such suffering may be mental only, and yet none the less a grievous affliction.

In the medical management of such patients, leading questions are less than ever allowable; and mere curiosity on the doctor's part is only less reprehensible than its insidious counterpart, namely, the taking vicarious sexual gratification in the patient's disclosures. Even the saints have to guard against this temptation!

But if no inquiry is permissible into the underlying sexual cause of these miseries, how then can they be relieved, some may ask. And the answer is, by inference from our intuitions, or in the same way a concealed malarial infection can be revealed by the curative effect of quinine. And fortunately in these cases there is no danger of ill effects from the treatment that may or may not be needed. What then is this panacea?

Repression is useless. The essential trouble is the conflict between the strongest of our instincts and the controlling efforts of the higher nerve-centres, or, as we may as truly say, of the soul. In this conflict the patient has suffered at least partial defeat, with its consequent humiliation. She instinctively believes that a physician, if he is a real man, will be better able than anyone else to give the help she needs. In this she is just as right as is the man who finally finds that only by woman's aid can he climb up out of similar sloughs of despair.

While the curative principle of understanding and diversion requires all sorts of modifications to meet the varying needs of such patients, the principle itself submits to this definition:

The higher nerve centres, that have surrendered either to sensations from the sexual reflex-centres or to the imagination, must be given exercise of similar and salutary nature.

The sexual instincts must therefore have reinterpretation. Their real parental nature must be recognized. Pride in their possession must replace shame.

If other women's babies or orphans are not available as outlets for our patients' motherly longings, never in any environment is there lack of similar cases of human helplessness. The real inspiration of many a ministering angel is her own heartache.

In this hurried sketch of sex hygiene, as a field where attention to the patient's personality is peculiarly important, it has been of course impossible to suggest, except in bare outline, the special treatments different patients need. But this does not matter. For, having taken my illustrations from this field of medical practice, my sole purpose has been to persuade you of the necessity, in the healing art, of first studying the patient's personality and then of making your sympathy helpful.

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